MONTANA MEDICAL ASSOCIATION

2021 Eleventh Avenue • Helena, Montana 59601-4890
Telephone 1-406-443-4000 FAX 1-406-443-4042
Toll Free in state 1-877-443-4000
http://www.mmaoffice.org e-mail: mma@mmaoffice.org

January 14, 2009
Wednesday

MEMORANDUM

TO: ***SENATOR ROY BROWN, CHAIR***
SENATE HEALTH AND HUMAN SERVICES COMMITTEE

FROM: ***JAMES W. CRICHTON, M.D.***

Dear Senator Brown:

I was born in Deer Lodge, Montana. I was first licensed to practice in Montana in 1969. After finishing military service and residency training, I practiced in Helena until I retired two years ago. I have been president of the Montana Academy of Family Physicians, Chief of Staff at St. Peters Hospital, and Medical Director of Blue Cross Blue Shield of Montana. Currently, I work as a part time consultant at Blue Cross Blue Shield and serve on the Medicaid Drug Utilization and Review Committee. I am a member of the MMA Executive Committee and Board of Directors. I have seen many earnest attempts by all of these entities to improve health care in our state and in our nation. Some things have occurred to me.

1. There is no simple solution. Government, the individual citizen, (patient), third party payers, physicians, and hospitals will all have to make some changes. Many of us still think that persuading each entity would give a better solution than a top down mandate from the Federal Government.

2. More and more often, we hear the assertion that "Health care is a right." The Declaration of Independence states: "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights..." I have examined the U.S. Constitution and the Montana Constitution and find that these documents enumerate those rights, liberties, and freedoms. Nowhere do I see that the citizen has a right to expect any specific financial benefit such as health care. Once we arbitrarily deem healthcare to be a $2,000,000,000,000 rights problem, we do ourselves the disservice of denying that it is actually a management problem, a solvable, but so far, unsolved, badly managed problem.

3. An Argument that starts with a faulty premise will lead to an invalid conclusion. Let us discard the faulty premise that health care is a right and find a better premise. I suggest the premise that we are spending more than enough money to have a good health care system, but some of the money is misspent and some is mal-distributed.

4. Government at various levels already pays for about half of all healthcare in the US. Medicare, Medicaid, Veterans, IHS, Tricare, SCHIP, Community Health Centers, and others that I either have forgotten or don't know about. The Feds should crunch these together into one before covering every American. The Medicare and Medicaid models have evolved a great deal in the 40 years they have been in place, and there is much to be said for them.

5. Insurance companies lose money by developing numerous and incomprehensibly complex products and procedures. (Medicare has only one benefit package and little or no sales force). That alone saves 20%, in

my opinion.

6. Hospitals mistakenly believe that beautiful bricks and mortar equal high quality health care. Perhaps, a beautiful building is easier to achieve than a staff of competent, content, and caring, professionals. Montana hospitals squander tens of millions of dollars that should be spent on actual health care instead of building beautiful buildings.

7. Physicians face pressures unthinkable a few years ago. These range from lawsuits, new kinds of competition, and several other factors that work to make today's physician only about half to two thirds as productive as he was twenty years ago. This leads to fee building and higher fees and unhappiness all the way around.

8. Patients, usually do not know anything about the above. They do not know the difference between insurance and prepaid health care. In President Bush's Medicare Improvement Act is the provision for high deductible coverage linked to Medical Savings Accounts. This mode has not been encouraged. Over the short term, it is less profitable for insurance companies. The average American thinks of finances in terms of days or weeks, not years. It is not widely known that less than 5% of people will have health care costs in one year that are greater than the amount of their premiums. In the insurance world, it is better to insure the unpredictable 5% chance of disaster and pay the 95% with one's own funds, i.e., Medical Savings Account. The power of this idea comes from reattaching medical decision making to someone's wallet. It would do a lot to improve the complex and sometimes felonious billing that we see every day, if at the end of a service, a bill had to be produced that would be understandable, fair, presented to the patient instead of a third party, and paid right then from a medical savings account, maybe with a credit card attached to the account.

9. The heavy hand of Government should be applied to make high deductible/Medical Saving Account coverage available at its actual cost. We should devise better insurance products that are simple, few, and understandable, and that explain and allow acceptable risk .The insurance companies should be asked to participate, but not dominate. All hospitals should be paid on a DRG like system that fairly reimburses actual costs to the non-profit hospitals, but doesn't allow for pie in the sky building programs and other excesses. Physicians' fees are well controlled by the Resource-Based Relative Value Scale. Physicians would be more cooperative in the overall effort if the system were a little more physician friendly. All of this would require a massive education program.

MONTANA MEDICAL ASSOCIATION

2021 Eleventh Avenue • Helena, Montana 59601-4890
Telephone 1-406-443-4000 FAX 1-406-443-4042
Toll Free in state 1-877-443-4000
http://www.mmaoffice.org e-mail: mma@mmaoffice.org

January 14, 2009
Wednesday

MEMORANDUM

TO: ***SENATOR ROY BROWN, CHAIR***
SENATE HEALTH AND HUMAN SERVICES COMMITTEE

FROM: ***KIRK L. STONER, M.D.***
PRESIDENT

Dear Senator Brown:

The MMA wants to thank you for including us in your discussions on the future of health care reform in Montana. I wish to apologize for not being here in person but practice obligations and the 1,000 mile round trip make appearance a hardship. In my place, Dr. Jim Crichton will participate for the MMA.

Physicians have long recognized that there is a significant strain in our system of health care. Organized medicine, the AMA, has been working on ideas for change for a number of years. Some of these recommendations have been collated into separate documents and are included for the committee's perusal. We have heard the present health care problem described in apocryphal terms such as 'crises.' Although the present system is less than ideal, we remind the committee that people are still being cared for, employees are getting paid and we still have a very professional dedicated patient centered work force.

The Montana Medical Association is appreciative of the efforts that the state has made to improve physician reimbursements through the state Medicaid program and the state's supportive positions on primary care.

The health care system problem is so large and the health care system so complex that it is very easy to get caught up in not seeing the forest because of the trees. For this reason we feel that it is very important to concentrate on paying attention to some general principles:

1) Everyone must be covered by a basic health plan. This will eliminate the need for providers to overcharge paying patients in order to make up for the non-paid losses.
2) There can be no discrimination because of existing health conditions
3) All patients must have access to a primary care provider
4) There have to be incentives for patients to follow effective preventative medicine practices
5) All people must have equal access to care
6) Government guaranteed care must be based on 'evidence-based medicine'

Other considerations that policy makers need to consider are:

A) Overview of health care at the national level
   1) The federal government presently provides approximately half of all the health care in the United States. They have the databases available to provide guidance in this endeavor.
   2) The United States spends more than any other industrial nation for health care, we have some of the poorest health outcomes data and we only insure 84% of our population.
   3) Populations of other industrial countries are generally pleased with the health care that they receive. There are many different types of health care systems available worldwide and they are a potential source of information as the US embarks on a modernization program.

B) Physician supply

1) Although surveys vary, there is general agreement that a large number of older physicians are planning on early retirement or retiring by age 65. This is the present pool of primary care providers. Primary care residencies are having a severe problem recruiting applicants. It takes at least seven years after college to train a physician and a few years in practice before that physician has the breadth of knowledge and experience to provide guidance to their patients. The clock is ticking.

2) For the past 20 plus years, physicians have been under price controls from the federal government and suffered on onslaught of administrative overburden from both government and insurance company fiats. This has resulted in the profession being gradually transformed into a business with predictable results. Physicians have gathered together in larger groups of various structure in order to cope with these administrative and financial restraints and many patients have found that they have lost the personal doctor patient relationship that is so important in the care of patients.

C) Some cost issues

1) Fancy buildings, high administrative salaries, high 'profit' margins, high administrative costs, all do nothing to care for patients and only add to medical costs. Something has to be done to control these nonproductive costs.

2) As people have less direct contact with the cost of their care, and as providers have less idea of the cost of the care they are providing, there becomes an understandable disconnect between the cost of medicine and the care provided.

3) Item '2' above creates a situation in which there tends to be unlimited demand for medical services and finite resources. This is the making of a disaster. It is imperative that someone takes responsibility for the cost of medical care. It is unfair to place this burden on the provider. It is the responsibility of the payer be it the individual, the insurance company or the government. This is the major hurdle that has to be overcome. Who will take responsibility to make this decision?

4) At a recent AMA meeting the IBM VP responsible for buying their health insurance worldwide presented a few facts that illustrate some of the cost issues facing the US:
   a) An IBM employee who lives in California and knows the name of his primary care provider has 30% less medical expenditures than an IBM employee who does not know the name of his primary care provider.
   b) The last 6 months of life of an IBM employee who dies in New York costs $150,000. A similar IBM employee who dies in Des Moines costs $30,000.
   c) A private conversation between an elderly man and his IBM employee son upon the awaking of the elderly man following pacemaker surgery: "how do I turn it off"?

5) Private insurance companies have two sources of income:
   a) Premiums
   b) Investments on premiums collected

   And three sources of expenses:
   a) Claims paid
   b) Administrative expenses
   c) Profit

   By law, publicly traded companies have a fiduciary responsibility to maximize their profits. That said, the private insurance companies must reduce claims or administrative expenses in order to increase profits. Reducing claims means not paying for medical services provided to their clients. By throwing administrative road blocks into the claims process insurance companies can reduce claims paid. It therefore does not make sense for them to reduce administrative costs because these costs have the effect of reducing their claims, therefore increasing profits.

On a personal note, I was raised in Sheridan County, Montana, and went through medical training and residency outside of the state and returned to Sheridan County in 1981 and have operated a private medical practice in Plentywood since that time. I have a modern facility with up-to-date equipment and a computerized medical record system that has been operational for over seven years. I have been using computerized financial software for over 15 years. All of this has been done

with personal funds. I have received no state or federal subsidies. When I retire there will be no physician to take my place. I had serious discussions with one of my children regarding going into medicine and advised against it. The medicine that I was trained in and grew up in has been destroyed and there is no going back. I wish the future generations of medical practitioners good luck.

A good physician provides his patient with information regarding the patient's condition and what treatment options there are for the affliction that the patient has. It is up to the patient to make the ultimate decision on what treatment they desire. The MMA takes the same position in testifying before this committee. We are happy to provide you with the information that you request as we know what that information is to be. It is up to you to make the decision on how you are going to use that information.

Overview of the AMA reform proposal

Problems of the U.S. health care system have become all too familiar: relentless growth in the number of the uninsured, skyrocketing costs, dwindling employee health benefits, avoidable illness, premature death, health disparities based on race, ethnicity and income ... Increasingly, many insured, middle-class Americans worry that rising health care costs will jeopardize their ability to access affordable coverage in the future for themselves and their families.

As advocates for patients, physicians have a particular stake in finding viable, effective approaches to ensure that everyone has health insurance coverage. The American Medical Association (AMA) has made covering the uninsured an ongoing, top priority, and its proposal to expand health insurance coverage and choice addresses the needs of all patients, regardless of income or health status. Through the "Voice for the Uninsured" campaign, the AMA is focusing public attention on health system reform as we move through the 2008 election cycle. The campaign encourages everyone to vote with these issues in mind and help drive change in the American health care system.

Synopsis

The AMA proposal to cover the uninsured and expand choice uses an approach advocated by growing numbers of scholars and policymakers from diverse quarters. The strategy is to pinpoint and address fundamental flaws in how people currently obtain and pay for health insurance in the United States, flaws that limit the availability and affordability of coverage, especially for those with low earnings or no employee health benefits. Dramatic improvement is possible by making better use of existing government resources devoted to health care and health care coverage, including the billions of dollars spent subsidizing employment-based private insurance. These resources should be drawn upon to, in essence, give people money to pay for a health plan of their choosing.

The AMA proposal would expand health insurance coverage and improve fairness by shifting government spending toward those most likely to be uninsured: people with lower incomes. It would also reduce the hidden bias favoring employment-based coverage, which provides special employee tax breaks for insurance obtained through an employer. Those without insurance through a job don't get this tax break, and would finally get assistance under the AMA proposal. Employees who are dissatisfied with their employers' health plan offerings could choose to buy insurance elsewhere and still be eligible for assistance. Especially in this context, health insurance market regulations should be reformed to establish fair "rules of the game" that protect vulnerable populations without unduly driving up premiums for the rest of the population. Regulations should also foster market experimentation to find the most attractive combinations of plan benefits, cost-sharing and premiums.

In short, the AMA advocates a clear role for government in financing and regulating health insurance coverage, with health plans and health care services being provided through private markets, as they are currently. The AMA proposal gives patients more control over our nation's health care dollars, while increasing affordability and choice. It reflects important social values and traditions, such as assistance based on need, freedom of choice, market innovation and fairness. Pragmatically, the AMA proposal is fiscally sound and permits flexible implementation—for example, any one of these pillars could be implemented independent of other reforms.

Three specific actions are needed to achieve this vision of covering the uninsured and strengthening our nation's health care system.

Three pillars: The foundation of the AMA proposal

The AMA proposal to expand health insurance coverage and choice is based on three pillars:

- **Subsidies for those who most need financial assistance obtaining health insurance.** This assistance could take the form of tax credits or vouchers, should be more generous at lower income levels, and should be earmarked for health insurance coverage. It is important to note that the government already gives people financial assistance to buy private health insurance—well over $125 billion each year—with an employee income tax break on job-based insurance that is hidden from public view. This tax break gives more assistance to those in higher tax brackets, and gives no assistance to those without employee health benefits. Shifting some or all of this assistance to tax credits or vouchers for lower-income people would reduce the number of uninsured and improve fairness in the health care system.
- **Choice for individuals and families in what health plan to join.** Today people are effectively locked into the health plans their employers offer, often just one or two plans,

which are subject to change from year to year. A change in employment typically means a change in insurance coverage. In contrast, under the AMA plan, people could use tax credits or vouchers to help pay for premiums of any available insurance, whether offered through a job, another arrangement or the open market. As with job-based insurance today, health plans would still have to meet federal guidelines for covered benefits, but people would have greater say in what types of benefits and plan features they value. Coupled with individual choice, tax credits benefit recipients directly, and everyone indirectly, by stimulating the market for health insurance. If enough people have enough purchasing power—and enough say over how that purchasing power is used—insurers will be compelled to offer better, more affordable coverage options.

- **Fair rules of the game that include protections for high-risk patients and greater individual responsibility.** For markets to function properly, it is important to establish fair ground rules. A proliferation of state and federal health insurance market regulations has made it more difficult and expensive for insurers to do business in many markets. The AMA proposes streamlined, more uniform health insurance market regulations. Regulations should permit market experimentation to find the most attractive combinations of plan benefits, cost-sharing and premiums. It is also important that market regulations reward, not penalize, insurers for taking all types of patients. People should have a guarantee that they will not lose coverage or be singled out for premium hikes due to changes in health status. Market regulations intended to protect people who have high health risks typically have backfired, sometimes disastrously, by driving up premiums for younger, healthier people and leading them to drop coverage.

  To help high-risk people obtain coverage without paying astronomical premiums, additional targeted government subsidies are needed for high-risk people that would allow insurers to keep premiums down in the regular market. Individuals also need to be encouraged to play fairly by taking responsibility for obtaining health insurance without waiting until illness strikes or medical attention is needed. People who are uninsured despite being able to afford coverage should face tax implications.

Conclusion

The three pillars of the AMA reform proposal, combined with careful consideration of ways to get the best value from health care spending, provide a prescription for achieving health insurance coverage for everyone. While additional details will have to be worked out, any meaningful course of action presents challenges of similar scope and magnitude. The AMA believes that unresolved questions can no longer stand in the way of action, and that covering the uninsured is both imperative and possible.

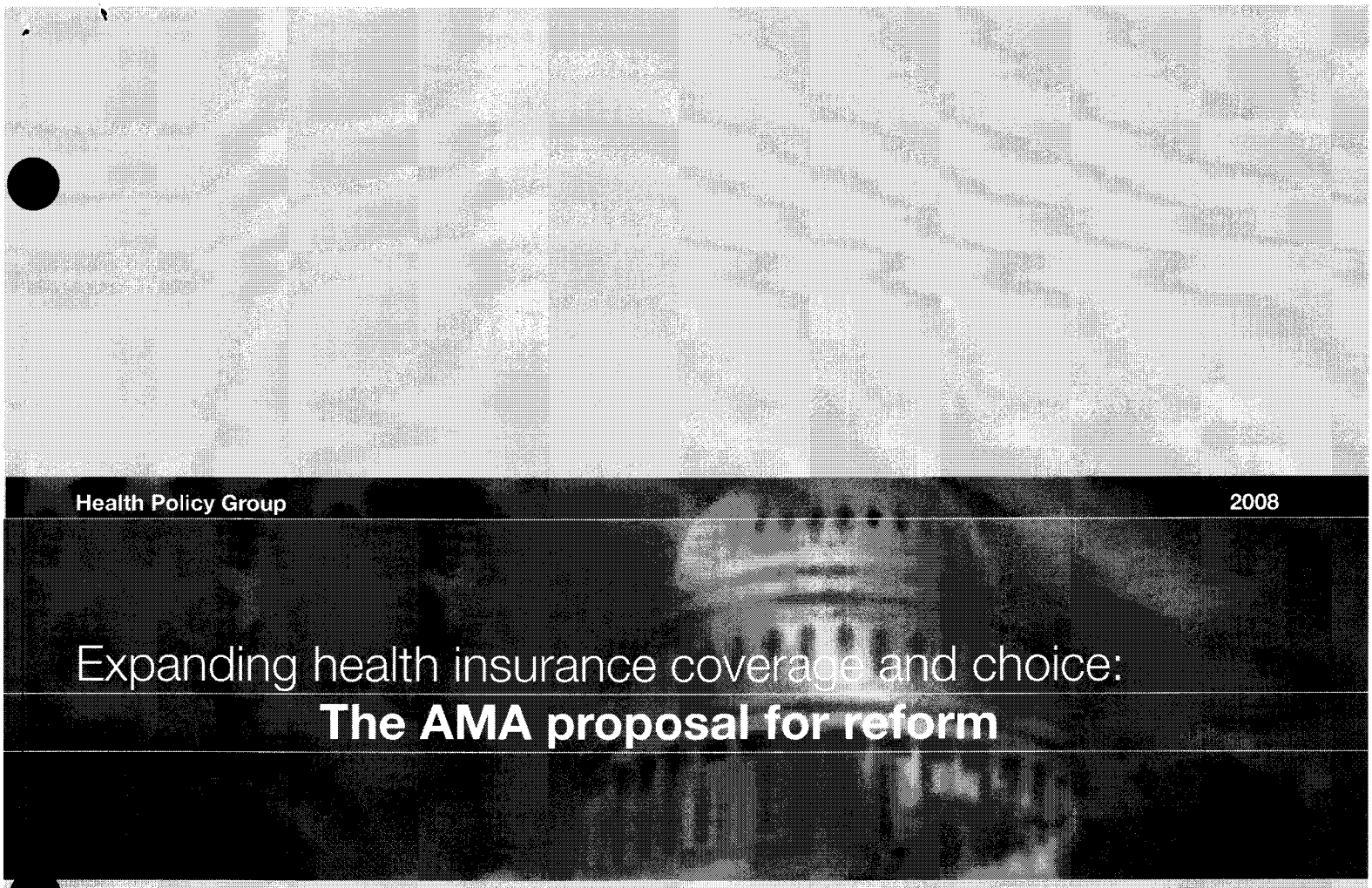
Visit *www.voicefortheuninsured.org* for more information on the AMA proposal and to view additional pieces in this series.

Health care costs

No health insurance reform proposal would be complete without giving serious consideration to managing health care costs. The AMA's work on developing solutions to address rising health care costs is ongoing, and its current focus highlights areas that physicians can influence. The AMA has identified four broad strategies to contain health care costs and achieve greater value for health care spending: reduce the burden of preventable disease; make health care delivery more efficient; reduce nonclinical health system costs that do not contribute to patient care; and promote value-based decision-making at all levels. The AMA's approach to gaining better control of health care costs is to ensure that we get the best value for our health care dollar.

AMA
AMERICAN
MEDICAL
ASSOCIATION

AJ:08-0185:5M:3/08



Health Policy Group 2008

Expanding health insurance coverage and choice:
The AMA proposal for reform

AMA
AMERICAN MEDICAL ASSOCIATION

Table of contents

Overview: The AMA reform proposal

Problems of the U.S. health care system have become all too familiar: 47 million uninsured, skyrocketing costs, dwindling employee health benefits, avoidable illness, premature death, health disparities based on race, ethnicity and income ... Even many insured, middle-class Americans feel the threat of precarious health insurance coverage, are concerned about indirectly shouldering the medical bills of the uninsured, or are simply troubled that so many lack access to care in a country that boasts the most sophisticated medical technology. Public opinion polls and appeals from large manufacturers alike show widespread support for some sort of health care reform, but no clear consensus on specific solutions. Proposed remedies vary in scope and approach, reflecting different diagnoses of the root causes of the system's ailments.

As advocates for patients, physicians have a particular stake in finding viable, effective approaches to these issues—especially the challenge of covering the uninsured. The American Medical Association (AMA) has made covering the uninsured an ongoing, top priority, and has developed a proposal to expand health insurance coverage and choice to all patients, regardless of income or health status. Through the "Voice for the Uninsured" campaign, the AMA is focusing public attention on health system reform as we move through the 2008 election cycle. The campaign encourages everyone to vote with these issues in mind and help drive change in the American health care system.

Synopsis

The AMA proposal to cover the uninsured and expand choice uses an approach advocated by growing numbers of scholars and policymakers from diverse quarters. The strategy is to pinpoint and address fundamental flaws in how people currently obtain and pay for health insurance in the United States, flaws that limit the availability and affordability of coverage, especially for those with low earnings or no employee health benefits. Dramatic improvement is possible by making better use of existing government resources devoted to health care and health care coverage, including the billions of dollars in subsidies for private health insurance. These resources should be drawn upon to, in essence, give people money to pay for a health plan of their choosing, with the amount of money they receive based on their income.

The AMA proposal would expand health insurance coverage and improve fairness by shifting government spending toward those most likely to be uninsured—people with lower incomes. It would also reduce the hidden bias favoring employment-based coverage, which provides special employee income tax breaks for insurance obtained through an employer. Reducing this bias has important advantages, as well as potential drawbacks, that must be addressed. Those without the option of insurance through a job don't get this tax break, and would finally get assistance under the AMA proposal. Employees who are dissatisfied with their employers' health plan offerings could choose to buy insurance elsewhere and still be eligible for assistance. Reducing the bias, however, could accelerate the decline in employment-based insurance, causing further disruption. Especially in this context, strong safeguards are needed to ensure that people with predictably high medical costs can afford coverage. Health insurance market regulations should be reformed to establish fair rules that protect vulnerable populations without unduly driving up premiums for the rest of the population. Regulations should also allow market experimentation to find the most attractive combinations of plan benefits, patient cost-sharing and premiums.

In short, the AMA advocates a clear role for government in financing and regulating health insurance coverage, with health plans and health care services being provided through private markets, as they are currently. The AMA proposal gives patients more control over our nation's health

care dollars, without sacrificing personal financial security or choice. It reflects important social values and traditions, such as assistance based on need, freedom of choice, market innovation and fairness. Pragmatically, the AMA proposal is fiscally sound and permits flexible implementation—for example, by improving market regulations independent of other reforms, phasing in changes in tax assistance for health insurance, or adapting reforms at the state level. Three specific actions are needed to achieve the full vision of covering the uninsured and strengthening our nation's health care system.

Three pillars: The foundation of the AMA proposal

The AMA proposal to expand health insurance coverage is based on three pillars:

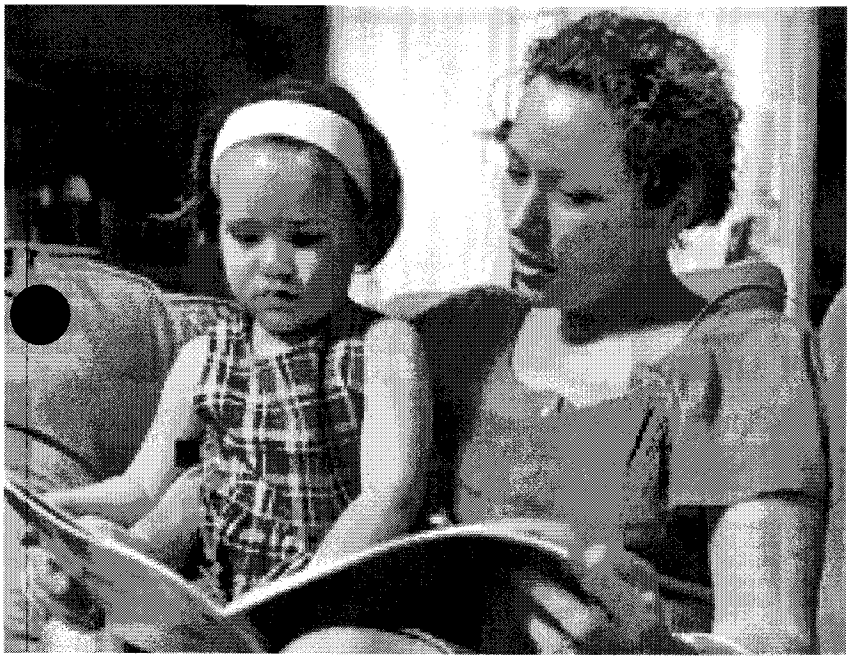
- **Helping people buy health insurance through tax credits or vouchers.** These tax credits or vouchers should be more generous at lower income levels, and should be earmarked for health insurance coverage. It is important to note that the government *already* gives people financial assistance to buy private health insurance—well over $125 billion each year. The form of this support—an employee income tax break on job-based insurance—is hidden from public view. This tax break gives more assistance to those in higher tax brackets, and gives no assistance to those without employee health benefits. Shifting some of this assistance to tax credits or vouchers for lower-income people would reduce the number of uninsured and improve fairness in the health care system. One way this can be achieved, for example, is by putting limits on the existing tax break so that employees do not get a bigger income tax break for simply enrolling in more expensive health plans. Under this scenario, premiums for employee health insurance below a specified limit could still be tax-free, with additional spending becoming subject to income tax. Limiting the $125 billion tax break for job-based insurance would yield additional revenue for the government, which could be used to fund tax credits and vouchers for those who currently get little or no assistance. The limit would also encourage insurers, employers and employees to avoid excessively generous health plans, curbing the rising cost of health care and insurance premiums.

- **Choice for individuals and families in what health plan to join.** Today, people are effectively locked into the health plans their employers offer, often just one or two, which are subject to change from year to year. A change in employment typically means a change in insurance coverage. In contrast, under the AMA plan, people could use tax credits or vouchers to help pay for premiums of any available insurance, whether offered through a job, another arrangement or the open market. As with job-based insurance today, health plans would still have to meet federal guidelines in covered benefits, but people would have greater say in what types of benefits and plan features they value. Coupled with individual choice, tax credits benefit recipients directly, and everyone indirectly, by stimulating the market for health insurance. If enough people have enough purchasing power—and enough say over how that purchasing power is used—insurers will be compelled to step up to the plate with better, more affordable coverage options that are within reach of more people.

- **Fair rules of the game: Regulating markets and protecting high-risk patients.** For markets to function properly, it is important to establish fair ground rules. A proliferation of state and federal health insurance market regulations has made it more difficult and expensive for insurers to do business in many markets. The AMA proposes streamlined, more uniform health insurance market regulations. Regulations should permit market experimentation to find the most attractive combinations of plan benefits, patient cost-sharing and premiums. It is also important that market regulations reward, not penalize, insurers for taking all types of patients. Market regulations intended to protect people with high health risks have typically backfired, sometimes disastrously, by driving up premiums for younger, healthier people and leading them to drop coverage.

  To help high-risk people obtain coverage without paying astronomical premiums, additional government subsidies are needed. Targeted assistance for coverage of high-risk people could take the form of risk adjustment payments to individuals or insurers, reinsurance of medical expenses beyond some catastrophic limit, or funding of separate high-risk insurance pools

that allow insurers to keep premiums down in the regular market. Individuals also need to be encouraged to play fair by taking responsibility for obtaining health insurance without waiting until illness strikes or medical attention is needed. At the same time, people should have a guarantee that they will not lose coverage or be singled out for premium hikes due to changes in health status. Conversely, people who are uninsured despite being able to afford coverage should face tax implications.



First pillar: Helping people buy health insurance through tax credits or vouchers

The AMA proposal to cover the uninsured and expand choice begins with providing individuals and families with income-based financial assistance to buy health insurance. The government already provides hefty tax assistance for purchasing health insurance, and it is clear that continued federal support will always be needed if everyone, regardless of income or health status, is to be assured of affordable, adequate, reliable health insurance. Unfortunately, the current federal subsidy for private health insurance—more than $125 billion each year—does not reach the people most in need of financial assistance and is available only to those with health insurance through a job. Dramatic improvement in coverage of the uninsured is possible by more effectively leveraging the vast resources already devoted to subsidizing health insurance. The AMA, along with a growing number of policymakers, believes that the current subsidy—an employee income tax exclusion for employment-based insurance—should ultimately be replaced with tax credits or vouchers, awarded to individuals and families on the basis of financial need, for use toward buying health insurance of their personal choosing.

What makes tax credits different?

Tax subsidies for health insurance can take several different forms. A tax exclusion or tax deduction reduces the amount of income tax a person owes by subtracting a given dollar amount from the amount of income that is taxed. After the exclusion or deduction is applied, the remaining income and the corresponding tax bracket are used to calculate the amount of income tax owed. (In tax jargon, tax exclusions and tax deductions are both types of tax exemptions that reduce a person's tax liability by reducing his or her taxable income. After the deduction or exclusion is applied, tax liability is calculated based on taxable income and the marginal tax rate.)

Tax credits, unlike most other tax subsidies, have the following features:

- Tax credits are subtracted directly from an individual's income tax bill, after all other calculations regarding tax brackets, deductions, etc., are made. Dollar for dollar, a tax credit reduces the recipient's tax liability.
- Tax credits can target assistance toward those most likely to be uninsured—people with lower incomes.
- Tax credits can be refundable, so that even those who owe little or nothing in income tax can still benefit from the subsidy.
- Tax credits can be "advanceable" so that they are available in advance, allowing recipients to use the credit toward insurance premium payments without waiting to file income taxes.
- Tax credits facilitate individual choice of health insurance, the second pillar of the AMA proposal.

For these reasons, the AMA believes that tax credits are a more fair, transparent and effective way of using government resources to help people buy private health insurance. For additional information on this issue, see "How the government currently helps people buy health insurance: The employee tax break on job-based insurance" and "Illustration of how tax credits or vouchers would affect households" in this series.

A word about vouchers

Like tax credits, vouchers are simply another vehicle for helping people buy health insurance, and can also be targeted to those most likely to be uninsured, and used for the recipient's choice of health insurance. A voucher program could be designed to work like an electronic benefit transfer debit card, as is used in the Food Stamp Program. Accordingly, the AMA supports the use of vouchers or other premium subsidies as long as they are designed in a manner consistent with AMA principles for structuring tax credits, described at right, and enable individuals and families to purchase their choice of health insurance.

Principles for structuring tax credits

For tax credits to work fairly and efficiently, they should be implemented based on the following principles:

Size of tax credits

- The dollar amounts of tax credits should be inversely related to income.
- The amounts of tax credits should be large enough to enable recipients to afford health insurance.
- The amounts of tax credits should vary with family size to mirror the pricing structure of insurance premiums.

Cap on tax credit amounts

- Tax credits should be fixed-dollar amounts for a given income and family structure, independent of health insurance expenditures, to encourage individuals to be cost-conscious and to discourage overinsurance.
- In the absence of fixed-dollar amounts, the size of tax credits should be capped in any given year to prevent overinsurance.

Eligibility for tax credits

- Tax credits should be contingent on the purchase of health insurance, so that those who do not obtain health insurance forfeit their credit.
- Tax credits for families should be contingent on each family member having health insurance.

Use of tax credits

- Tax credits should be applicable to health insurance of the individual's choice, regardless of whether coverage is obtained through an employer or elsewhere.
- Tax credits should be applicable only for the purchase of health insurance, and not for out-of-pocket health expenditures.

Administration

- Tax credits should be refundable, so that if the credit exceeds taxes owed, the individual receives the

credit in the form of a payment. This means that individuals with incomes too low to pay income tax still would be eligible for tax credits to buy health insurance.

- Tax credits should be advanceable for those with low incomes, so that these individuals receive the credit to pay for health insurance coverage before such payment is due and do not have to wait to be reimbursed when they file their income taxes.

Growing support for tax credits

There is growing recognition that tax credits are preferable to tax deductions, tax exclusions or other income tax breaks because they more effectively target low-income individuals. Over the past several years, many think tanks reflecting a range of political views have developed opinion papers and issue briefs outlining the advantages of tax credits over tax deductions and exclusions, and demonstrating how credits can be used to facilitate the expansion of health insurance coverage. Similarly, editorials in a number of major newspapers emphasize that issuing tax credits inversely related to income would distribute resources much more efficiently than allowing people to deduct health insurance expenditures from taxable income. As concern for the uninsured has increased over the past several years, members of Congress from both parties have introduced legislation that would provide tax credits to help individuals obtain health insurance.

Over the short term, this shift in the way tax subsidies are distributed for the purchase of health insurance is likely to result in some loss of subsidy for upper-income individuals. Over the long term, however, all income groups will benefit from lower medical inflation due to increased competition among insurers and less uncompensated care. In addition, individuals would be able to purchase the exact amount of coverage they need to keep their family secure, rather than overinsuring because of lack of plan choice and financial consequence.

Second pillar: Individual choice of health insurance

The second pillar of the AMA proposal to cover the uninsured is individual choice of health insurance. Individual choice is facilitated by the other two pillars of the AMA proposal: *income-related tax credits or vouchers* for use toward any available health plan, whether offered through a job or elsewhere, and *regulatory reforms* to allow market experimentation to search out the most attractive combinations of plan benefits, patient cost-sharing and premiums, as well as new venues to obtain health insurance. Under the AMA proposal, individuals and families will be able to pick the coverage that meets their needs and preferences, choosing from a wide range of health plans, not just the fixed number of benefit designs selected by a human resources department or government agency. In addition, because people will own their own health insurance, they will be able to keep it regardless of any job changes.

To be clear, individual choice of health insurance should not be confused with purchasing coverage on the current individual (non-group) market for health insurance. Currently, the individual market primarily serves those who do not have access to coverage through a job or public program, while prohibiting some people from securing coverage on reasonable terms, if at all. Nor should individual choice be confused with eliminating employment-based coverage, which has distinct pros and cons. Rather, the AMA proposal allows for new opportunities to buy health insurance in addition to employment-based coverage. These new opportunities would emerge in an environment characterized by individual choice and ownership, equivalent tax breaks regardless of type or source of insurance, a surge in the number of people able to afford coverage, fair market regulations, and clear standards of individual responsibility for having health insurance.

Limited choice, high cost of health insurance

A major argument for employment-based group insurance is lower per-person administrative expenses of marketing, enrollment, underwriting, etc. However, actual premiums paid for insurance bought on the individual market are, on average, a remarkable 60 percent to 65 percent lower than premiums for employment-based insurance ($1,776 vs. $4,479 for single coverage, and $4,128 vs. $12,106 for family coverage, according to eHealthInsurance.com[1] and the Kaiser HRET Employer Health Benefits Survey, 2007.[2] These substantial premium differences are due largely to the fact that many people, when given a choice, opt for less generous coverage than is typically offered by employers. These results also indicate that allowing individuals to determine which insurance benefits are not worth higher premiums—individual choice—is an effective means of reining in runaway health care costs and premiums, without sacrificing highly prized benefits or health care.

In 2007 only 13 percent of all employers offered employees a choice of health plans. Moreover, between 2000 and 2007, the number of employers offering health insurance declined from about 70 percent to 60 percent, while the share of the non-elderly population with employment-based insurance also eroded from about 70 percent to 60 percent. Additional challenges with employment-based insurance include lack of portability, which can lock employees into jobs to avoid losing coverage, and discontinuity when employers switch plans. In addition, those without insurance through a job receive none of the $125 billion annual federal subsidy for job-based health insurance.

Expanded opportunities for group coverage

Under the AMA proposal, various types of groups—such as coalitions of small employers, unions, trade associations, farm bureaus, alumni associations, churches and religious groups, and ethnic coalitions—would become able, and eager, to sponsor health plans. Conditions would also become ideal for the formation of group purchasing associations similar to the Federal Employees Health Benefits Program (FEHBP), and state or multi-state health insurance exchanges such as the Massachusetts Connector. The FEHBP, which provides coverage to federal employees, including members of Congress, and their families offers a varied menu of health plans, benefits and premiums that have already been negotiated and pre-screened for solvency, licensing and related criteria.

Existing tax rules and regulations virtually preclude group insurance other than through employment. The existing employee tax break for buying health insurance applies exclusively to employment-based insurance. Moreover, both overregulation and arbitrary differences in regulation across 50 states and the District of Columbia create unnecessary complexity and cost that prevent realization of economies of scale. The AMA believes these barriers should be removed, and that the regulatory environment should enable, not impede, the development of new group insurance and purchasing associations. Rather than regulating minimum size, number of plans offered, geographic restrictions, etc., the government should allow the market to determine the details and success of purchasing associations based on economies of scale and other natural advantages.

Likewise, employment-based health insurance has administrative economies of scale, and surveys show that many employees value the comfort and convenience of having their employers choose their coverage. Accordingly, employers will continue to offer health insurance to the extent that the market demands it, rather than in response to preferential tax treatment and regulation. At the same time, employees who are dissatisfied with their employers' health plan offerings can decide to buy elsewhere without forfeiting a tax break on their insurance or having to change jobs to get the coverage they prefer.

Evolution of the individual market

For the past decade, the share of the non-elderly population with individual market coverage has hovered around 6 to 7 percent. The ability to shop for

1. eHealthInsurance.com. *The Cost and Benefits of Individual Health Insurance Plans: 2007. www.ehealth insurance.com/content/expertcenterNew/CostBenefitsReportSeptember2007.pdf.* Published September 2007. Accessed November 19, 2007.

2. The Kaiser Family Foundation and Health Research and Educational Trust. Employer Health Benefits 2007 Annual Survey. *www.kff.org/insurance/7672.* Publication 7672. Published September 2007. Accessed November 2, 2007.

health insurance through the Internet has stimulated individual-market coverage, which would continue to evolve under the AMA proposal, offering a greater choice of affordable coverage options, and possibly becoming less distinguishable from the group market. Such market developments will ultimately benefit people across risk and income classifications. For example, the influx of a critical mass of average-risk people into the individual market would reduce the cost-effectiveness to insurers of individually risk-rating applicants. Costly medical underwriting practices would likely be replaced by simplified, automated ones, particularly as purchasing insurance over the Internet becomes more common. The result would be de facto community rating of premiums—but as the byproduct of natural market evolution rather than by market regulation.

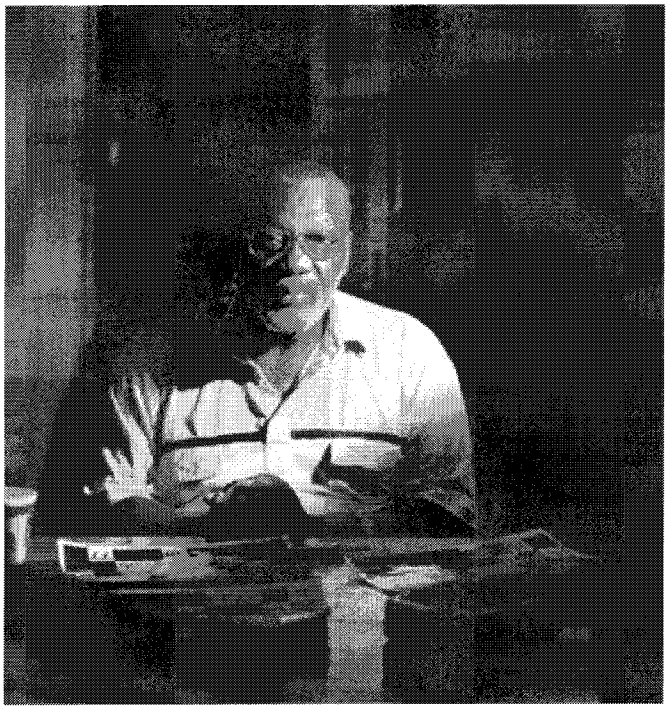
However, the AMA also recognizes that special measures are needed to address the needs of the chronically ill and disabled, and supports targeted subsidies for coverage of high-risk individuals, as described in the third pillar of the AMA plan. Risk-based subsidies, in addition to having a direct impact, would also elicit market response, such as the development of specialized facilities or integrated delivery systems for people with specific chronic conditions, offering the full range of services required to manage and treat the condition and common co-existing conditions.

Choosing a health plan

The FEHBP provides consumer information and assistance for comparing and choosing health plans, including annual information fairs and online decision-support tools. High demand for consumer information has also spurred enterprising publishers to issue inexpensive, authoritative, user-friendly guides to FEHBP health plans (available at newsstands and in drugstores throughout the Washington, D.C., area each year during open enrollment season). Co-workers also exchange valuable information, passed along through word-of-mouth. In the same manner, new group purchasing associations and insurance exchanges would provide consumer information and support with plan selection, with additional formal and informal assistance forthcoming as well. As reflected by the growth of consumer-driven health care, many people are becoming more interested in being personally involved in health care decision-making, as they already are for other major personal choices, such as car and home insurance, mortgages, and education.

Compelling insurers to step up to the plate

Individual choice and ownership of health insurance would have a profound effect on insurer behavior, market function and the types of available plan choices. Large insurers currently dominating many markets will face challenges from smaller insurers and other new sources of coverage. No longer insulated from being accountable to individual enrollees and potential enrollees, insurers will become more responsive to patients' concerns. Because enough people will have enough purchasing power—and enough say over how that purchasing power is used, insurers will be compelled to step up to the plate with better, more affordable coverage options that are within reach of more people.



Third pillar: Fair rules of the game—regulating markets and protecting high-risk patients

The third pillar of the AMA proposal to expand health insurance coverage and choice calls for fair rules that allow health insurance markets to function properly while also protecting high-risk patients. With appropriate health insurance market regulations and federal subsidies based on income and health risk, every individual would be able to find affordable coverage in every state.

The "crazy quilt" of regulations

Since the early 1990s, numerous state and federal health insurance market regulations have been introduced to make coverage affordable and comprehensive, particularly for people with chronic or expensive medical conditions. An excessive number of state and federal regulations apply to various health insurance markets. Even within states, different rules apply to large employer groups, small employer groups and individuals. Regulations may also differ by type of health plan and by individual factors such as health risk, age or prior coverage. Compared with large groups, small groups are treated unfavorably by federal law, particularly the Employee Retirement Income Security Act (ERISA), which exempts large, self-insured groups from state benefit mandates and market regulations.

Insurance regulations have often had unintended consequences, making coverage more expensive and driving more people into the ranks of the uninsured. Regulations intended to protect high-risk individuals typically penalize health plans for enrolling people with above-average medical costs, giving insurers incentives to avoid the sick and cherry-pick the healthy. Similarly, regulations often backfire by driving up premiums for younger, healthier people, leading less expensive enrollees to drop coverage. In addition, the sheer number, variety and complexity of regulations has added to the cost of providing insurance.

A good example of how health insurance market regulations can backfire is the combination of strict community rating, extensive benefit mandates and guaranteed issue.

Strict community rating means that everyone enrolling in the same health plan pays the same premium regardless of health risk, so that the cost of covering care for expensive enrollees is spread across the community of people buying insurance.

Benefit mandates require health plans to cover specified health services. While any one benefit mandate might have little impact, cumulatively they can add significantly to the cost of health insurance.

Guaranteed issue means that insurers must accept all applicants, allowing healthy individuals to forgo coverage knowing that they can always buy insurance later should they fall ill.

These regulations make premiums inordinately expensive for people in good health or with low incomes. The greater the number of healthy people who decide to go uninsured, the higher the average cost of health care among those with insurance, and the higher premiums must be to reflect and cover average costs. In the extreme, a *death spiral* leaves fewer and sicker individuals with insurance, drives up premiums, and eventually cripples or destroys the market for health insurance.

The proliferation of market regulations has also increased insurers' costs of administration and regulatory compliance. The variation in regulatory environments makes it more difficult and expensive for insurers to operate in multiple states or markets, preventing the realization of economies of scale and inhibiting the emergence of new types of group purchasing arrangements. By both increasing the costs of offering insurance and reducing demand from relatively healthy people, market regulations have driven insurers out of some states, reducing competition among remaining insurers.

A better approach

The AMA proposes streamlined, more uniform health insurance market regulation, building upon the lessons of state experiences. Regulations should protect high-risk individuals without unduly driving up health insurance premiums for the rest of the population. Regulations also should encourage the creation of innovative and affordable heath insurance options, as well as new group purchasing arrangements. Insurers are likely to consent to, or even welcome, such market regulations, as long as they know that they are operating on an even playing field in which all insurers and plans must play by the same rules. The AMA has developed a set of guiding principles for health insurance market regulation. These fair rules are an integral part of the AMA proposal to cover the uninsured and expand choice but can be implemented independently, at the state or federal level.

Guiding principles for health insurance market regulation

The AMA supports the following principles for health insurance market regulation:

- **There should be greater national uniformity of market regulation across health insurance markets, regardless of type of submarket (i.e., large group, small group, individual), geographic location or type of health plan.** Differential regulations add to administrative costs, prevent realization of economies of scale and impede new group purchasing arrangements. Limited state variation in market regulation should be permitted as long as it does not drive up the number of uninsured, unduly hamper the development of multi-state group purchasing alliances or create adverse selection across states.

- **The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements.** Benefit mandates should be minimized to allow market experimentation to find the most attractive combinations of plan benefits, patient cost-sharing and premiums. Removal of legislative and regulatory barriers, as well as greater uniformity in regulations, would open up opportunities to buy insurance as part of a group, buy multiyear insurance contracts and invest in other innovations that would not only reduce administrative costs but narrow premium differences between high- and low-risk individuals. More flexible regulations could also allow development of specialized coverage for people with chronic conditions, offering better coordination of care, reduction of wasteful services and quality improvements.

- **Individuals and families who can afford coverage should be required to obtain it.** Those earning greater than 500 percent of the federal poverty level ($52,000 for an individual and $106,000 for a family of four in 2008) should be required to obtain at least catastrophic and preventive coverage, or face adverse tax consequences. The requirement would extend to people of all incomes only after implementation of subsidies for those who need financial assistance obtaining coverage (i.e., sliding-scale, refundable tax credits or vouchers to buy insurance). A requirement to have insurance would make it less cost-effective for insurers to risk-rate individual applicants. Simplified, automated underwriting would result in de facto modified community rating, as the natural byproduct of market function rather than as a result of market regulation. See more in "Individual responsibility: Requiring those who can afford it to have health insurance" in the series.

- **Health insurance coverage of high-risk patients should be subsidized by using risk-related assistance—such as subsidies for high-risk pools, reinsurance and risk adjustment.** Explicit, targeted government subsidies are needed to help high-risk people obtain coverage without paying prohibitively high premiums, and to make high-risk people more attractive to insurers. Risk-based subsidies such as high-risk pools, reinsurance and risk adjustment can expand coverage for people of *all* risks. For example, by providing subsidized health plans for high-risk individuals, high-risk pools give insurers reassurance that they are unlikely to end up with an unfavorable selection of high-cost enrollees in the regular market, allowing them to offer lower premiums and making coverage attractive to the young and healthy.

- **Risk-related subsidies should be financed through general tax revenues rather than through strict community rating or premium surcharges.** Financing risk-based subsidies with general tax revenues rather than through premiums avoids the unintended consequences of driving up premiums and distorting health insurance markets.

- **Strict community rating should be replaced with modified community rating.** By allowing some degree of premium variation based on individual risk factors, but limiting premium differences within specified risk bands, modified community rating strikes a balance between protecting high-risk individuals and the rest of the population. Some degree of age rating is acceptable, as are lower premiums for nonsmokers, but an individual's genetic information should not be used to determine his or her premiums or eligibility for coverage.

- **Guaranteed issue regulations should be replaced by guaranteed renewability, and those wishing to switch health plans should face limited re-underwriting.** Just as homeowners cannot buy home insurance after their homes catch fire, people should not be allowed to wait to buy health insurance until they need medical attention, as under guaranteed issue. Guaranteed renewability would protect individuals from losing coverage or being singled out for premium hikes due to changes in health status, rewarding people for obtaining and maintaining coverage. Similarly, people who wish to switch health plans should face limited underwriting and pre-existing condition limitations, compared with those who are newly seeking coverage.

Conclusion

These three pillars provide a prescription for achieving health insurance coverage for everyone. While additional details and implementation practicalities will have to be worked out, any meaningful course of action presents challenges of similar scope and magnitude. The AMA believes that unresolved questions can no longer stand in the way of action, and that covering the uninsured is both imperative and possible.

Visit *www.voicefortheuninsured.org* for more information on the AMA proposal and to view additional pieces in this series.

Frequently asked questions about the AMA proposal for reform

Q: What are the basic principles of the AMA proposal?

A: The American Medical Association (AMA) proposes that individuals and families receive financial assistance to purchase a health plan of their choice, with more generous assistance to those with lower incomes. The financial assistance could take the form of tax credits or vouchers and must be earmarked for health insurance coverage. Health insurance market regulations should be reformed to establish fair "rules of the game" that protect vulnerable individuals, without unduly driving up premiums for the rest of the population.

Q: How does the AMA suggest funding its plan?

A: The AMA proposes eliminating or capping the employee income tax exclusion that the federal government currently provides for employment-based health insurance, which would provide the federal government with more than $125 billion annually. In addition, the AMA supports redistributing the public funds currently spent on uncompensated care—funds that are provided to institutions to compensate for the higher operating costs for treating the uninsured—and using tobacco tax revenue for the expansion of health care services.

Q: Isn't health insurance on the individual market a terribly expensive and confusing proposition?

A: Not necessarily. According to a 2007 eHealthInsurance.com and Kaiser HRET Employer Health Benefits Survey, actual premiums paid for insurance bought on the individual market are, on average, 60–65 percent lower than premiums for employment-based insurance. These substantial premium differences are due largely to the fact that many people, when given a choice, opt for less generous coverage than is typically offered by employers. In addition, there is evidence that health insurers are increasingly competing in the individual market, which improves the chance of finding an affordable health insurance policy. Finally, individuals purchase many types of insurance on their own. The AMA believes that the growth in the availability of individually owned insurance would be accompanied by new educational materials to help with selection.

Q: What about people with pre-existing conditions?

A: The AMA supports protecting high-risk patients by advocating direct subsidies provided through high-risk pools, risk adjustment and reinsurance. Existing indirect market regulations such as strict community rating and guaranteed issue have proven to be crude and ineffective in protecting high-risk patients. Too often, the indirect approach drives up health insurance premiums and the number of the uninsured.

Q: Will the AMA proposal encourage employers to drop health insurance benefits?

A: No. Employers offering health benefits currently do so voluntarily in order to attract and retain workers, and will continue to do so to the extent that the market demands it, regardless of whether the AMA proposal is implemented. Under the AMA proposal, health benefits for employees will continue to be deductible business expenses even if they are provided in the form of defined contributions to employees.

Q: What about cost? Will health insurance be affordable under the AMA proposal?

A: Affordability of health insurance depends not only on health coverage choices and premiums in the transformed market but also on the amount of the financial assistance provided. The tax credits or vouchers must be sufficient to cover a substantial portion of the premium costs for individuals of lower incomes. At the lowest income levels, the tax credits or vouchers should approach 100 percent of the premium.

Q: What is the government's role under the AMA proposal?

A: In short, we advocate a clear role for government in financing and regulating health insurance coverage, with health plans and health care services being provided through private markets, as they are currently. The AMA proposal gives patients more control over our nation's health care dollars, without sacrificing personal security or choice. It reflects important social values and traditions, such as assistance based on need, freedom of choice, market innovation and fairness.

Q: Does the AMA support mandated coverage?

A: The AMA supports greater individual responsibility, but not a mandate. Individuals would be free to choose not to have health coverage and face tax consequences such as forgoing incentives, penalties or a combination of the two. The AMA advocates individual responsibility to purchase health insurance coverage only for individuals and families with incomes greater than 500 percent of the federal poverty level (FPL). Those with incomes below 500 percent of the FPL would not be required to obtain coverage until a system of tax credits or other subsidies is implemented.

Q: Does the AMA proposal address the problem of people becoming uninsured when they are between jobs?

A: Yes. For most Americans, a change in employment status typically means a change in insurance coverage. In contrast, under the AMA proposal, people could use tax credits or vouchers to help pay for premiums of any available insurance, whether offered through a job, another arrangement or the individual market. Purchases of individual health insurance would not be affected by a job change.

Q: How is the AMA proposal different or better than a single-payer system?

A: Both the AMA and the single-payer approaches emphasize the same goal of universal coverage, but they differ on how to implement it. The AMA does not believe that full government control is a workable model for the United States. Single-payer systems are plagued with an undersupply of medical personnel, long waiting periods and a lack of patient choice. Alternatively, the AMA proposal seeks to enhance patient choice and encourage patients to be conscious of health insurance costs, while also maintaining innovation in the private sector.

Q: Does the AMA recommend a defined or standard set of health benefits?

A: No. The AMA believes that benefit mandates should be minimized to permit a wide choice of coverage options and allow market experimentation to find the most attractive combination of benefits, deductibles, copayments and so forth. The AMA has developed a framework for evaluating the adequacy of health benefits, one that provides enough guidance to minimize the incidence of inadequate health insurance coverage and enough flexibility to permit individuals to choose plans that reflect their needs and preferences.

Q: Would individuals who do not owe taxes be able to receive the tax credit?

A: Yes. The AMA supports refundable tax credits so that if the credit exceeds taxes owed, the individual receives the credit in the form of a payment that would be applied toward the purchase of health insurance.

Q: If I have a high income, will my taxes increase under the AMA proposal?

A: Perhaps, but the AMA proposal does not place an income ceiling on tax credit eligibility. It is likely, however, that in the interest of affordability, actual legislation would include an income ceiling and target the financial assistance to those who have lower incomes. Everyone, regardless of income or tax credit eligibility, will benefit from the new system. For instance, individual tax credits will greatly alter the individual health insurance market, which will address some of the problems of health insurance being linked to employment and difficulty obtaining pre-Medicare retirement coverage. In addition, enabling more Americans to purchase health insurance will reduce the hidden costs of uncompensated care, which increase taxes and contribute to rising health insurance premiums.

Q: Does the AMA support HSAs?

A: Yes. The AMA supports greater choice of coverage and, accordingly, supports health savings accounts, or HSAs, as an option for patients. To learn more about HSAs, see "HSA at a Glance."

Q: How does the AMA suggest implementing its proposal?

A: The AMA proposal—which advocates enhancing patient choice while also expanding health insurance coverage—could be implemented incrementally or in a more comprehensive fashion. For example, the AMA supports individual tax credits for specific target populations and capping the tax exclusion for employment-based health insurance as incremental steps toward implementing our proposal. In addition, many of the regulatory reforms supported by the AMA to protect vulnerable individuals without increasing premiums for the rest of the country could be implemented independent of other elements.

Visit *www.voicefortheuninsured.org* for more information on the AMA proposal and to view additional pieces in this series.

AMA
AMERICAN MEDICAL ASSOCIATION

AJ38:08-1407:PDF:1/09:db

Administrative costs of health care coverage

Administrative costs are frequently cited in debates about health system reform. There is widespread agreement that excessive costs and unnecessary burdens are imposed by complex procedures for filing insurance claims; countless Medicare, Medicaid and state insurance regulations; and new cottage industries that assist third-party payers with billing, repricing payments to physicians and hospitals, managing pharmaceutical benefits, and other nonclinical activities. The American Medical Association (AMA) advocates reducing administrative and other nonclinical costs that do not contribute value to patient care as one of several broad strategies to address rising health care costs (see "Strategies to address rising health care costs" in this series). While proponents of alternative approaches to health care reform agree that administrative costs represent an opportunity for cost-savings, they differ over the magnitude of potential savings and proposed solutions. Shedding light on health care administrative costs can narrow disagreement over alternative approaches to health system reform and provide a common basis for making evidence-based public policy decisions.

Different diagnoses, different prescriptions

The single-payer view holds that excessive administrative costs are inherent to any system of multiple, competing insurers, making private insurance less efficient than public programs such as Medicare, Medicaid and the State Children's Health Insurance Program. High administrative overhead, insurer profits and multiple sets of procedures for filing insurance claims are seen as a central cause of the inefficiencies and inequities of the current system, and are believed to account for unfavorable cost and health comparisons between the United States and other countries. This analysis and point of view supports the position that private health insurance should be replaced by government-provided coverage, with administrative savings more than offsetting the additional costs of covering everyone.

The AMA has a contrasting view, one that sees excessive administrative costs as secondary to—and symptomatic of—fundamental flaws in the way health insurance is currently provided and paid for. According to this view, many people are unfairly shut out of the health insurance system because of ill-conceived government policies—specifically, health insurance tax subsidies that don't help the poor, and health insurance regulations that don't protect the sick. Flawed tax and regulatory policies are also blamed for driving up administrative costs by imposing 51 arbitrarily different sets of insurance rules from states and the District of Columbia, which, in turn, drive all but the largest insurers out of many markets, often giving them excessive market power. This diagnosis points to a very different prescription for expanding coverage and curbing administrative costs: Redesign health insurance tax breaks, market rules and safeguards so that health insurance markets work properly, and so that coverage is affordable for everyone, regardless of income or health status. This approach, described more fully elsewhere in this series, is advocated by a broad range of individuals, policymakers and organizations.

Frequently cited administrative cost estimates

Given the wide variation in administrative cost estimates, government data provide a natural reference point. The annual National Health Expenditures (NHE) accounts report administrative expenditures of $143 billion in 2005. This amounts to 7.2 percent of total U.S. health care spending, broken out as 14.1 percent for private insurers and 5.2 percent for public programs (3.1 percent for Medicare and 7.0 percent for Medicaid). NHE data also show more rapid growth of administrative expenditures for public programs than for private insurance in recent years.

By comparison, industry estimates of administrative costs of private health plans generally are somewhat lower than NHE because they do not count insurer profits as part of administrative costs. Such inconsistencies in how administrative costs are defined make it difficult to determine the extent to which differences in estimates reflect differences in health plan efficiency.

Unlike industry or NHE estimates, other measures include a broader array of administrative costs not limited to those incurred by insurers, yielding estimates that are orders of magnitude higher. A study conducted by prominent single-payer advocates amassed data from the United States and Canada on the expenses of physicians, hospitals and employers for filing insurance claims, maintaining medical records, administering employee health benefits and so forth.[1] The study found that administrative expenditures in the United States were four times higher than reported by NHE in 1999, or 31 percent of total health care spending, compared with only 17 percent in the predominantly government-run Canadian system. Similarly, within the United States, administrative expenses associated with private insurance were found to be much higher than those of Medicare. The authors concluded that the bulk of these costs could be avoided if the United States were to adopt a Canadian-style health care system.

A closer look at administrative costs

These frequently cited estimates have been criticized for incorrectly measuring and reporting administrative costs in various ways that, together, exaggerate differences between private and public insurance, and the United States and Canada. Major shortcomings of administrative cost estimates include the following:

- **Ignoring unreported administrative costs of government programs.** Perhaps the most obvious shortcoming of many estimates is that they ignore unreported spending on administration of government programs. Such uncounted administrative costs are especially evident in the Medicare program and include:
  - Tax collection to fund Medicare—this is analogous to premium collection by private insurers, but whereas premium collection expenses of private insurers are rightly counted as administrative costs, tax collection expenses incurred by employers and the Internal Revenue Service do not appear in the official Medicare or NHE accounting systems, and so are usually overlooked
  - Medicare program marketing, outreach and education
  - Medicare program customer service
  - Medicare program auditing by the Office of the Inspector General
  - Medicare program contract negotiation
  - Building costs of the Centers for Medicare & Medicaid Services (CMS) dedicated to the Medicare program
  - Staff salaries for CMS personnel with Medicare program responsibilities
  - Congressional resources exhausted each year on setting Medicare payment rates for services

- **Reporting administrative costs as percentages rather than dollars.** Presenting administrative costs as a percentage of total health care costs gives a misleading impression of Medicare's efficiency relative to private insurance. Medicare patients are an expensive population, with much higher medical costs per person and per claim relative to the general privately insured population. Thus, an identical dollar amount of administrative cost per enrollee or per claim in the two sectors would make Medicare administrative costs appear lower. For example, a $10 administrative cost per insurance claim represents 10 percent of a $100 claim but only 1 percent of a $1,000 claim. Similarly, rising medical costs of Medicare enrollees create the appearance that Medicare is becoming administratively more efficient over time.

- **Confusing costs of regulatory compliance with health plan inefficiency.** Private insurers face administrative costs not imposed on public programs, such as the need to comply with multiple sets of state and federal regulations. Both overregulation and arbitrary differences in regulation create unnecessary administrative costs and prevent cost-savings from economies of scale. Private insurers also must pay premium taxes, usually counted as an administrative expense, driving up administrative costs as a percentage of total costs and creating the appearance of reduced efficiency.

- **Failing to recognize indirect costs not reflected on an accountant's ledger.** Tallying up dollars spent on all administrative activities for public and private insurance alike, along with addressing the other issues just discussed, would greatly improve administrative cost estimates and comparisons—but still would not capture indirect, hidden costs of insurance administration. These indirect costs depend on how basic administrative functions are accomplished, functions that are necessary for both private and public insurance, including collecting revenues, managing use of services, and paying physicians and hospitals. Adopting a single-payer system in the United States might eliminate health plans' administrative expenditures on curbing use of services, for example, by preauthorizing services, establishing tiered benefits, and monitoring the practice patterns of physicians and hospitals. However, these activities would inevitably be replaced by other methods of curbing overuse that carry their own costs, such as longer waiting times and restricted treatment options.

Toward fairer comparisons

Several analyses have sought to make fair comparisons between private and public insurance by addressing common shortcomings of administrative cost estimates. A pair of studies of Medicare administrative costs that included unreported expenditures on the program made by numerous government agencies concluded that Medicare administrative expenditures were at least three times the amount reported in the federal budget in 2003—$15.0 billion vs. $5.2 billion.[2,3] Another administrative cost analysis—possibly the most comprehensive and methodologically rigorous to date—examined a wide array of costs borne by insurers, health care providers, and patients in the United States and Canada, paying particular attention to indirect costs of carrying out basic administrative functions.[4] The study calculated costs, net of associated benefits, of explicit and implicit methods of collecting revenues, curbing use of services and paying providers. For example, longer waiting times in Canada implicitly keep utilization of health care services in check, generating indirect costs to patients from delayed treatment and missed work. The study found that indirect, hidden administrative costs dwarfed monetary expenditures, concluding that true administrative costs are many times higher in Canada than in the United States.

Administrative costs in perspective

The AMA believes that usual methods of estimating administrative costs ignore important facts, thereby overstating differences between private and public insurance, and that administrative costs are actually lower than generally reported in the private sector and higher than generally reported in the public sector. Furthermore, the AMA believes that even if administrative dollar expenditures were indisputably lower in a single-payer system, any administrative advantages would be offset by inefficiencies, longer wait times, restricted individual choice, lost productivity, reduced quality and decreased incentives for medical innovation. Likewise, the AMA regards administrative costs as being overshadowed by other, more fundamental flaws in the current health care system that, if corrected, would put coverage within everyone's reach regardless of income or health status, as well as rein in excessive administrative costs. In short, the AMA advocates a clear role for government in financing and regulating health insurance coverage, with health plans and health care services continuing to be provided through private markets, as they are currently. As described throughout this series, the AMA proposal reflects important social values and traditions—such as assistance based on need, freedom of choice, market innovation and fairness—by giving patients more control over our nation's health care dollars, without sacrificing personal security or choice.

What to do?

That being said, there clearly is room to improve the administrative efficiency of the U.S. health care system. The AMA supports the following specific measures to simplify needlessly complex administrative procedures and regulations:

- Develop and adopt a consistent format for defining, estimating and reporting administrative costs, in order to facilitate unbiased comparisons across different types of insurance and health care systems.
- Achieve greater national uniformity of market regulation across health insurance markets, regardless of type of submarket (e.g., large group, small group, individual), geographic location or type of health plan.
- Encourage the continued development of patient- and physician-friendly electronic systems to efficiently handle pricing, billing and claims processing at the point of service.
- Press the insurance industry to adopt more standardized claims-filing processes.
- Reduce nonclinical health system costs that do not meet cost-effectiveness criteria of adding value to patient care.
- Institute broader reforms to promote value-based decision-making so that decisions of insurers, patients, physicians and others take both costs and benefits into consideration. As described in "Strategies to address rising health care costs," decision-making can be improved through increased market competition, greater availability and transparency of information, and incentives.

Visit *www.voicefortheuninsured.org* for more information on the AMA proposal and to view additional pieces in this series.

References

1. Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. *N Engl J Med.* 2003;349(8):768–775.
2. Litow ME. *Medicare versus Private Health Insurance: The Cost of Administration.* Milliman Inc. *www.cahi.org/cahi_contents/resources/pdf/CAHIMedicareTechnicalPaper.pdf.* Published January 6, 2006. Accessed November 20, 2007.
3. Matthews M. *Medicare's Hidden Administrative Costs: A Comparison of Medicare and the Private Sector.* Council for Affordable Health Insurance. *www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf.* Published January 10, 2006. Accessed November 19, 2007.
4. Danzon PM. Hidden overhead costs: is Canada's system really less expensive? *Health Aff.* 1992;11(1):21–43.

How the government currently helps people buy health insurance:
The employee tax break on job-based insurance

The first pillar of the American Medical Association (AMA) proposal to expand health insurance coverage is to provide subsidies for those who need financial assistance in order to afford coverage. Although many people don't realize it, the federal government already provides more than $125 billion a year to subsidize the purchase of private health insurance. Those who benefit from the subsidy, unfortunately, are not necessarily those who need it most. In fact, just the opposite is true. Eligibility for the current subsidy—the employee tax break on employment-based health insurance—depends only on whether an individual has employee health benefits.

Three-quarters of all people covered by employment-based insurance have household incomes greater than $50,000, and half greater than $75,000. By contrast, people with incomes less than $25,000 make up only 7 percent of those with job-based coverage, which means that those who could benefit most from the subsidy—low-income individuals—are not even eligible to receive it.

Among the uninsured, two-thirds have incomes less than $50,000. Nonetheless, 80 percent of the uninsured have one or more tax-paying workers in the household. As such, even though employment-based insurance is the most common form of health care coverage, employment in no way guarantees access to affordable care. And, unless these working taxpayers can find a way to get health benefits through their employers, they are shut out of the $125 billion tax subsidy.

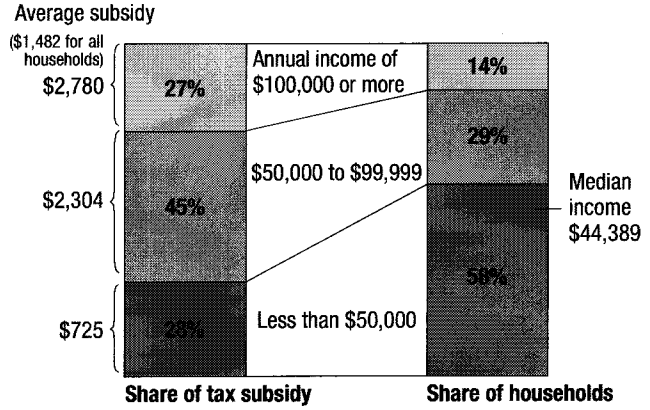
How the current subsidy works

Under the current federal subsidy, the government subsidizes the purchase of health insurance by excluding employers' expenditures on health insurance from the employee's taxable income. The specific form of this tax break is an employee income tax exclusion. There is no evaluation of financial need, and no attempt is made to adjust for variations in plan choice (e.g., how comprehensive the coverage is) that may result in greater or lesser premiums. The amount of subsidy one receives is based on whether coverage is job-related, how expensive the premiums are, and the individual's income tax bracket. People who purchase their own health insurance, or workers who are not offered, or cannot afford, insurance through their employers, receive no tax break at all.

Moreover, the amount of subsidy increases with income, since an employee income tax exclusion benefits individuals in higher tax brackets more than those in lower tax brackets. For example, someone in the 28 percent tax bracket with health insurance benefits worth $5,000 receives a $1,400 income tax break (28 percent of $5,000), whereas someone in the lower-income 15 percent tax bracket with the same health benefits receives only a $750 tax break (15 percent of $5,000). (See "Illustration of how tax credits or vouchers would affect households" in this series for a more detailed numerical example.) Furthermore, the relationship between income and subsidy is amplified by the fact that higher-income people are more likely to work for companies offering insurance and, on average, are offered or choose more expensive coverage. At the end of the day, the average employee tax break on employment-based insurance is nearly four times greater for households earning more than $100,000 than for households earning less than $50,000—that is, $2,780 compared with only $725.

As a result, the lion's share of the annual $125 billion subsidy goes to those with higher incomes. As shown in the figure, more than a quarter (27 percent) of the subsidy goes to the 14 percent of households with annual incomes greater than $100,000. Nearly three-quarters (27 percent plus 45 percent) of the subsidy goes to the less than half (14 percent plus 29 percent) of households with annual incomes greater than $50,000. And only about a quarter of the subsidy goes to the majority (58 percent) of households earning less than $50,000.

Who receives the $125 billion federal tax subsidy for employment-based health insurance, 2004[a]



a. Sources: Adapted from *Health Affairs* and the U.S. Census Bureau.[1,2]

Employers who offer health insurance to their employees generally do so in lieu of paying higher wages. If wages and health insurance premiums paid by employers are thought of collectively as income, individuals who do not receive health benefits from their employers are taxed on their full income, whereas those who participate in employment-based coverage are only taxed on a portion of their income. Moreover, if those who do not receive coverage from their employers buy coverage elsewhere, they must do so with post-tax dollars, without the help of a tax break. Thus, it can even be argued that the income tax exclusion for employment-based health insurance directs subsidies toward higher-income workers at the expense of lower-wage earners. More than 80 percent of the uninsured are workers who pay taxes—taxes that help the federal government afford to subsidize health insurance for other workers.

Support for change

There is growing recognition that the current tax treatment of employment-based health insurance plans is unfair and fails to make the best use of public dollars to facilitate the purchase of health insurance. Over the past several years, many think tanks reflecting a range of political views have developed opinion papers and issue briefs outlining the advantages of tax credits over tax deductions and exclusions, and demonstrating how credits can be used to facilitate the expansion of health insurance coverage. Editorials in a number of major national newspapers have lamented the historical quirk that has linked employment to health insurance since wage controls were imposed during World War II.

The inequity of the tax exclusion for employment-based insurance was highlighted in 2007 when the administration proposed to eliminate the employee tax exclusion as the way to level the playing field for those who do not get health insurance through their jobs. Although the administration's proposal advocated tax deductions as the means of offering tax breaks for the purchase of private health insurance, members of Congress from both parties have introduced legislation advocating the use of tax credits to help individuals obtain health insurance.

Along with growing numbers of scholars and policymakers from diverse quarters, the AMA believes that the current tax exclusion of employment-based health insurance should be replaced by refundable, advanceable tax credits which could be awarded to individuals and families to use toward the purchase of health insurance. Eliminating or capping the tax exclusion and redirecting the subsidy toward tax credits would be a more fair and rational way to subsidize health insurance and expand coverage to the uninsured.

A step in the right direction

The AMA recognizes that the employee income tax exclusion for job-based insurance is unlikely to be eliminated overnight. The political viability of abruptly eliminating the tax exclusion is reduced by the fact that there would be some loss of subsidy for upper-income individuals, as well as possible disruption of existing coverage arrangements. Thus, a more likely starting point would be for the government to place a limit on the existing employee income tax exclusion so that, for example, employees do not get a bigger income tax break simply for enrolling in more expensive health plans. Under this scenario, expenditures on an employee's health insurance might continue to be tax-free up to a premium limit, with additional spending for more expensive coverage becoming subject to income tax. Limiting the $125 billion tax break on job-based insurance would yield additional revenue for the government, which could be used to fund tax credits and vouchers for those who currently get little or no assistance. The limit would also encourage insurers, employers and employees to avoid excessively generous health plans, curbing inflation in premiums and health care services.

Visit *www.voicefortheuninsured.org* for more information on the AMA proposal and to view additional pieces in this series.

References

1. Sheils J, Haught R. The cost of tax-exempt health benefits in 2004. *Health Aff.* 2004. doi: 10.1377/hlthaff.w4.106. Published February 25, 2004. Accessed November 19, 2007.
2. DeNavas-Walt C, Proctor BD, Lee CH. *Income, Poverty, and Health Insurance Coverage in the United States: 2004.* Washington DC: US Census Bureau; August 2005. Current Population Reports, P60-229. *www.census.gov/prod/2005pubs/p60-229.pdf.* Accessed November 19, 2007.

AJ:08-0368:500:04/08ta (3)

AMA AMERICAN MEDICAL ASSOCIATION

Strategies to address rising health care costs

U.S. health care spending continues to rise faster than the overall economy, wages and inflation. As a nation, we now spend more than $2 trillion per year on health care—$7,000 per person, or 16 percent of gross domestic product. Rising health care costs are inextricably linked to growth in the number of uninsured, making it imperative that health system reform include efforts to address rising costs. The American Medical Association (AMA) has identified four broad strategies to contain health care costs and achieve greater value for health care spending:

- Reduce the burden of preventable disease.
- Make health care delivery more efficient.
- Reduce nonclinical health system costs that do not contribute to patient care.
- Promote value-based decision-making at all levels.

These strategies should be implemented to bring immediate improvement to the health care system, and to strengthen the impact of the comprehensive reforms—that is, financial assistance for those who most need help buying health insurance, personal choice of coverage and fair health insurance market rules—described elsewhere in this series.

Better value for health care spending

The ultimate public policy goal is to achieve better value for health care spending, rather than reduce cost alone. Value can be thought of as the best balance between the benefits and costs of health care, and better value can be thought of as improved clinical outcomes, quality of care and patient satisfaction per dollar spent. The goal is not necessarily to reduce utilization of health care but to find the most valuable use of services in accordance with their relative benefits and costs. Indeed, additional spending has yielded substantial clinical, economic and quality-of-life benefits, such as helping to dramatically reduce death rates for cardiovascular disease since the 1960s. Thus, the likely, but not guaranteed, result of focusing on value would be lower per capita health care spending, with slower or negative cost growth over time.

Why are costs so high?

- **The rising toll of preventable illness.** Studies have shown that a major contributor to the growth in aggregate health care spending is the marked increase in patients receiving treatment for diabetes, high blood pressure and other chronic conditions. Higher rates of treatment for such conditions primarily reflect an increase in disease prevalence, as opposed to earlier detection and/or more aggressive treatment than in the past. For example, rates of obesity and diabetes have doubled over the past 25 years, and more than a quarter of recent spending growth is attributable to the rise in obesity and related growth of diabetes, high cholesterol and heart disease. Other major sources of avoidable mortality, morbidity and cost include modifiable lifestyle behaviors such as unhealthy nutrition, physical inactivity, smoking and excessive alcohol use, as well as motor collisions, gun violence, domestic violence and other forms of trauma. Minorities experience markedly higher rates of chronic illness and injury, suggesting that targeted initiatives might yield greater overall improvement in health outcomes, in addition to reducing health disparities.

- **Inefficiencies in the health care system.** Inefficiencies in health care delivery add cost and detract value from the health care system. For example, recent studies have documented, on the one hand, costly overuse of diagnostic testing during routine preventive exams and, on the other hand, underuse of services recommended by clinical guidelines, including preventive services and care for high blood pressure, high cholesterol and diabetes. Factors contributing to inefficient use of services include fragmentation of care, lack of available cost-effectiveness information and lack of incentives to consider both costs and benefits in health-related decisions—for example, fragmented delivery of health care results in repeated medical histories and duplicative diagnostic tests because patient records are not readily available. Fragmented care also leads to futile end-of-life care, defensive medicine and missed opportunities for patients to receive lifestyle counseling. In addition, administrative costs, profits, marketing and other nonclinical spending often add to health system costs without contributing demonstrable value to patient care. Waste arises from unnecessarily complex procedures for filing insurance claims; countless state insurance regulations; and an excessive proliferation of new cottage industries to assist insurers with billing, pharmaceutical benefit management, determination of medical necessity, repricing of payments to providers and regulatory compliance.

Broad strategies

The AMA has identified the following four broad strategies to address rising health care costs and achieve greater value for health care spending:

- **Reduce the burden of preventable disease.** Reduce risk factors for disease and prevent the onset of chronic illness; improve patient compliance with medications and preventive care recommendations; encourage improved nutrition and physical activity; prevent injury due to accidents and violence; and conduct public health campaigns.

- **Make health care delivery more efficient.** Improve coordination of care; reduce unnecessary use of services; increase use of services with positive return on investment (i.e., in terms of future disease and cost); increase availability of information on relative cost-effectiveness of different treatments; improve management of chronic illness; reduce medical errors; and shift care to cost-effective sites of service (e.g., physicians' offices and clinics vs. emergency rooms).

- **Reduce nonclinical health system costs that do not contribute to patient care.** Eliminate all activities that do not meet the cost-effectiveness criteria of adding value to patient care, e.g., excessive spending on administration, profits and marketing (see "Administrative costs of health care coverage" in this series).

- **Promote value-based decision-making at all levels.** Improve the processes by which decisions are made so that they take into consideration both cost and benefit—particularly clinical outcomes. Both information and incentives are needed to improve a host of private and public decisions. Value can be increasingly integrated into such decisions as physicians and patients choosing among drug therapies, insurers designing health plan features, and legislators determining public health budgets or mandated coverage of particular benefits.

Necessary actions

The AMA has identified a short list of specific crosscutting, synergistic actions to help put these broad strategies into effect.

- **Promote patient lifestyle counseling.** Support routine lifestyle counseling by physicians through adequate insurance payment; inclusion of lifestyle counseling in quality measurement and pay-for-performance initiatives; medical education; and information technology systems. Provide complementary patient support through educational materials, healthy lifestyle reward programs, and insurance coverage of services such as nutrition counseling and prescription drugs to aid smoking cessation.

- **Support cost-effectiveness research.** Give funding priority to medical research that uses both cost and clinical evaluation criteria; translates findings into useable information; and widely disseminates information to physicians, patients and other decision-makers.

- **Apply consistent cost-effectiveness criteria.** Support ongoing analysis of nonclinical activities in order to reduce costs that do not add value to patient care.

- **Continue development of health information technology.** Design systems to automatically provide relevant, timely and actionable information, e.g., clinical guidelines and protocols; cost-effectiveness information; quality measurement and pay-for-performance criteria; patient-specific medical and insurance information; prompts for lifestyle counseling and care management; and alerts to flag and avert medical errors.

- **Use clinical performance and quality measurement to improve efficiency.** Encourage development and adoption of measures aimed at reducing overuse of unwarranted services and increasing use of recommended services known to yield cost savings.

- **Encourage use of targeted benefit design by insurers.** Encourage insurers to reduce or waive patient cost-sharing for chronic illness medications, particularly when patient noncompliance poses a high risk of adverse clinical outcome and/or high medical costs.

- **Reduce health disparities based on race and ethnicity.** Support medical care, insurance coverage and public health initiatives targeted toward underserved populations in order to achieve greater overall impact.

- **Build broad coalitions of stakeholders.** Recognize that while physician leadership is essential, confronting endemic problems such as obesity, tobacco use and violence will require societal change and collaboration within and outside the health care system.

Visit *www.voicefortheuninsured.org* for more information on the AMA proposal and to view additional pieces in this series.

AJ:08-0368:5M:4/08 ta (1)

AMA
AMERICAN
MEDICAL
ASSOCIATION

Protecting high-risk patients

The third pillar of the American Medical Association (AMA) reform proposal is "fair rules of the game" that include protections for high-risk patients. High-risk patients are the small portion of the population that has, or is likely to have, very high medical expenses due to a pre-existing medical condition, family history or similar risk factor. Ensuring that even the highest-risk patients have adequate and affordable health care coverage is critical to the success of any health reform effort. The AMA believes that direct subsidies provided through high-risk pools, risk adjustment and reinsurance hold the greatest promise of protecting high-risk patients. This direct approach to protecting high-risk patients stands in contrast to the customary approach, which is to regulate the sale of health insurance, particularly in markets serving individuals and small employers. Market regulations have proven to be a crude and indirect way of protecting high-risk patients that, too often, drive up health insurance premiums and the number of uninsured.

Types of direct risk-based subsidies

- **High-risk pools**—remove high-risk individuals from the regular health insurance market, making premiums more affordable for the general population and offering high-risk enrollees at least one coverage option. Directly providing coverage to those with the highest medical expenses through high-risk pools can markedly reduce the average per-person cost in the regular insurance market. To date, high-risk pools have been used more often than risk-adjustment or reinsurance. More than 30 states operate high-risk pools, in which enrollees pay 125 to 150 percent of standard premiums. Although premium revenues typically fall short of enrollees' medical expenses, these shortfalls are made up through a combination of government subsidies and insurer revenues from the standard market.

- **Risk adjustment**—adjusts payments to health plans based on the risk of their enrollees (e.g., on the basis of health status, previous health claims and/or age). High-risk individuals remain in the regular insurance market, but additional payments are given to insurers with a disproportionate share of high-risk enrollees. Insurers collect revenues commensurate with projected costs of each enrollee, motivating them to enroll anyone regardless of health risk.

- **Reinsurance**—provides insurance for insurers, whereby the reinsurer pays some share of an individual or group's medical expenses beyond a pre-specified limit. Whereas high-risk pools and risk adjustment target individuals projected to have high medical expenses, reinsurance subsidizes care of individuals who have actually incurred high medical expenses.

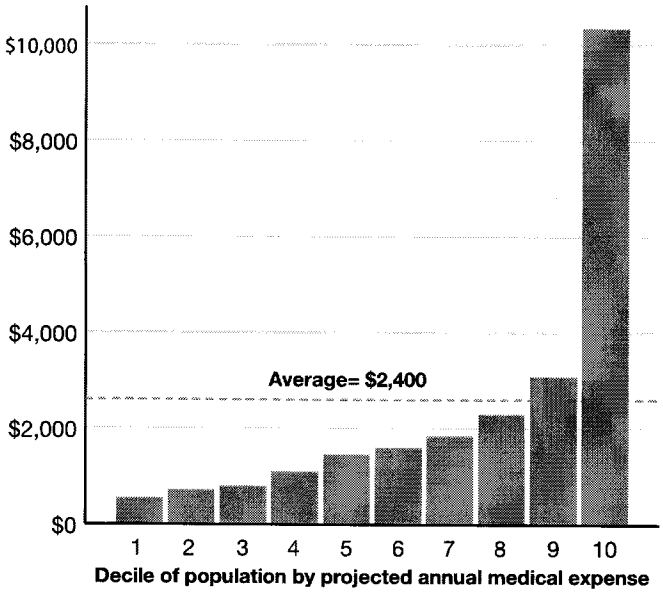
How the indirect approach has backfired

Since the early 1990s, numerous state and federal regulations have been introduced in an attempt to make coverage more affordable and comprehensive for those with predictably high medical expenses. These market regulations include strict community rating of premiums, benefit mandates for coverage of specified medical services and guaranteed issue to health plan applicants. Under "strict community rating" everyone in the same health plan pays the same premium regardless of health risk, so that the cost of covering expensive enrollees is spread across the community of people buying insurance. "Benefit mandates" require health plans to cover specified health services. While any one benefit mandate might have little impact, cumulatively, mandates can add significantly to the cost of health insurance. "Guaranteed issue" requires insurers to accept all applicants.

The idea of these regulations is that relatively healthy people pay higher premiums than they otherwise would, so that those in poor health can pay lower premiums than they otherwise would. In effect, coverage of high-risk patients is subsidized by an unofficial sales tax added to most individuals' insurance premiums. Elected officials rely on market regulations to finance these subsidies because legislating regulations is generally easier than officially raising taxes.

The figure on the reverse side helps illustrate how these regulations drive up premiums for people in good health and limit affordable health plan options for everyone. Each bar shows the amount of individual medical expenses anticipated for the upcoming year for one-tenth (decile) of the population. The 10 percent of individuals at the far right of this highly skewed distribution have projected expenses of approximately $10,000, more than three times the next-highest decile ($3,000) and four times greater than average ($2,400). A community-rated premium based on average cost of $2,400 would exceed projected costs for 80 percent of the population and double premiums for the lowest-risk individuals. Faced with community-rated premiums that are inordinately expensive relative to the odds of having unexpectedly high medical expenses, many people opt not to buy health insurance. Not surprisingly, many of the nation's uninsured are young, low-income workers who may be starting careers and families, but who do not have employee health benefits and cannot afford to buy coverage on their own.

Distribution of projected medical expenses for individuals under age 65[a,b]



a. Adapted from data contained in Exhibit 1 of Pauly and Herring, *Health Affairs*, May/June 2007.[1]
b. Data is from the 1996–2002 private insurance market and is expressed in 2002 dollars.

Benefit mandates also require coverage to be more generous and expensive than many people would prefer. Furthermore, guaranteed issue regulations invite free-riding by allowing people to postpone buying insurance until they need medical attention. The greater the number of healthy people who go uninsured, the higher the average cost of health care among those with insurance, and the higher premiums must be to reflect and cover average costs. During the 1990s, just such a cycle of rising premiums and diminishing enrollment played out in heavily regulated states such as New Jersey, Vermont and Kentucky. Another unfortunate irony of market regulations is that they give insurers financial incentives to avoid the sick and cherry-pick the healthy. When everyone pays the same premium, health plans lose money on higher-risk enrollees and make elevated profit on lower-risk enrollees.

How the direct approach is better

Direct risk-based subsidies such as high-risk pools, risk adjustment and reinsurance differ from market regulations in the following important respects:

- Risk-based subsidies directly assist high-risk individuals, whereas market regulations, by altering the price and covered benefits of health insurance, indirectly transfer financial assistance from low-risk people to high-risk people.
- Risk-based subsidies provide appropriate incentives for insurers to cover high-risk individuals without requiring high-risk individuals to pay prohibitively high premiums.
- Risk-based subsidies can be financed with general tax revenues rather than insurance premium revenues, thereby avoiding unintended consequences of market regulations, such as raising overall premium levels.

As with any method of protecting high-risk patients, direct subsidies allow high-risk enrollees to pay much less on their own than the premiums required to fully cover their expected medical expenses. In contrast to indirect approaches, however, direct subsidies enable health plans to collect enough revenues to cover costs when enrolling high-risk patients. In contrast to community rating in particular, other enrollees pay lower premiums that are more in line with their costs, thereby expanding coverage for people of all risks.

Financing subsidies to cover high-risk patients with general tax revenues rather than through community-rated premiums avoids pricing standard-risk people out of the insurance market and limiting health plan choice. Addressing the free-rider problem by replacing guaranteed issue with guaranteed renewability would protect those already enrolled in health plans from losing coverage or being singled out for premium hikes should they be struck by illness. Replacing market regulations with risk-based subsidies would also allow greater market flexibility and innovation, such as specialized coverage for people with chronic conditions.

Based on the lessons of states' experience, the AMA believes that market regulations should be replaced with direct risk-based subsidies to protect high-risk patients, while also allowing health insurance markets to function properly for the rest of the population. Fair rules of the game, including direct subsidies for coverage of high-risk patients, are an integral part of the AMA proposal to cover the uninsured and expand choice—and can be implemented independently, at the state or federal level.

Visit *www.voicefortheuninsured.org* for more information on the AMA proposal and to view additional pieces in this series.

Reference

1. Pauly MV, Herring B. Risk pooling and regulation: policy and reality in today's individual health insurance market. *Health Aff.* 2007;26(3):770–779.

AJ:08-0542:5M:5/08 ta (2)

AMA AMERICAN MEDICAL ASSOCIATION

Illustration of how tax credits or vouchers would affect households

The first pillar of the American Medical Association (AMA) proposal to cover the uninsured is financial assistance to buy health insurance, provided through tax credits or vouchers. By giving more generous assistance to individuals and families with lower incomes, tax credits or vouchers differ fundamentally from the existing tax break on job-based insurance, which gives more assistance to higher-income workers and none to those without job-based insurance.

Tax breaks for buying health insurance

The federal government provides more than $125 billion per year in assistance for health insurance through the current employee income tax break, about three-quarters of which goes to households earning more than the median income. Shifting this assistance to tax credits or vouchers for people with lower incomes would reduce the number of uninsured and improve the fairness of the health care system. The most straightforward way to do this would be to eliminate the existing employee income tax break (i.e., tax exclusion) for job-based health insurance, and use the newly generated government revenues to fund tax credits and vouchers for those who currently get little or no assistance. "How the government currently helps people buy health insurance: The employee tax break on job-based insurance" in this series explains how different tax subsidies help people obtain health insurance.

Replacing the tax exclusion with tax credits

The table on the next page illustrates how two families would be affected if the government were to replace the existing tax break for job-based insurance with tax credits. To illustrate the contrast between the status quo and the AMA proposal, the example assumes that the tax break for job-based health insurance is completely eliminated. Tax credits are introduced that follow principles advocated by the AMA—for example, being inversely related to income and large enough to make insurance affordable.

It is important to note that the AMA reform proposal is guided by broad policy principles rather than specific parameters. As such, the AMA proposal does *not* specify dollar amounts for tax credits, and the tax credits shown are hypothetical and illustrative. Actual changes will depend on specific tax credit amounts, income levels, tax rates, and current and future coverage choices.

A numerical example: two families

The example shows the tax break, or subsidy, each family receives under the current income tax exclusion for job-based insurance. By not paying federal income taxes on $7,500—the compensation the employer gives the employee by paying health insurance premiums—Family 1 receives a subsidy of $1,125. This subsidy represents 11 percent of the $10,000 premium, making Family 1's effective premium $8,875, or 17.8 percent of the $50,000 family income.

Family 2 receives a subsidy of $2,100, equal to 21 percent of the premium, making Family 2's effective premium $7,900, or 4.5 percent of the $175,000 family income. Note that Family 2 receives a bigger subsidy than Family 1, and that Family 2 effectively pays almost a thousand dollars less than Family 1 for the same coverage ($7,900 for Family 2 compared with $8,875 for Family 1).

Different impacts on each family

Replacing the current tax exclusion with the hypothetical tax credits shown gives Family 1 a net subsidy gain of $6,375. Family 1's $7,500 tax credit equals 75 percent of the $10,000 premium, and the new effective premium, $2,500, represents 4 percent of the $50,000 family income.

Replacing the tax exclusion with a $1,000 tax credit gives Family 2 a net subsidy loss of $1,100. Family 2's tax credit equals 10 percent of the premium for a new effective premium of $9,000, or 5 percent of the $175,000 family income. The share of family income spent on health insurance by Family 1, the lower-income family, declines significantly (from 18 percent to 4 percent), whereas the share of income spent on health insurance by Family 2 increases slightly (from 4.5 percent to 5.1 percent).

Visit *www.voicefortheuninsured.org* for more information on the AMA proposal and to view additional pieces in this series.

(Continued on the next page)

AMA
AMERICAN MEDICAL ASSOCIATION

Impact of hypothetical tax credits on two families

Family 1		Family 2
Basic family health insurance and tax information		
Families 1 and 2 are both enrolled in the same job-based health plan with premiums of $10,000, for which their employer pays 75% of the total premium. Both families file their income taxes jointly, but Family 2 has higher annual income than Family 1. In both cases, the salary shown equals the family's income.		
$10,000	Health insurance premium	$10,000
$7,500	Premium paid by employer (75% of total)	$7,500
$50,000	Salary reported on employee's W-2 tax form	$175,000
15%	Tax bracket	28%
Before: Financial assistance received under the current employee income tax exclusion		
n/a	Premium paid by employer reported on employee's W-2 tax form	n/a
$50,000	Adjusted gross Income (as reported on family's 1040 federal income tax form)	$175,000
$1,125	**Subsidy (tax break) from the current employee income tax exclusion** (premium paid by employer times employee's tax rate)	**$2,100**
11%	Subsidy as a percentage of premium	21%
$8,875	Effective premium (total premium minus subsidy)	$7,900
17.8%	Effective premium as share of salary	4.5%
After: Financial assistance when tax credits replace the employee income tax exclusion		
Premium payments by employers on behalf of employees become subject to employees' federal income tax, while individuals and families receive tax credits toward payment of health insurance premiums (regardless of whether coverage is obtained through a job or elsewhere). In this hypothetical example, Family 1 receives a $7,500 tax credit and Family 2 receives a $1,000 tax credit.		
$7,500	Premium paid by employer reported on employee's W-2 tax form	$7,500
$57,500	New adjusted gross income (salary plus premium paid by employer)	$182,500
$1,125	Additional income tax (premium paid by employer times employee's tax rate, equals old subsidy)	$2,100
$7,500	**Subsidy (tax break) from tax credit** (actual dollar amounts could be different)	**$1,000**
+ $6,375	Net change in subsidy (equals change in disposable income)	- $1,100
75%	Subsidy as a percentage of premium	10%
$2,500	Effective premium (total premium minus subsidy)	$9,000
5.0%	Effective premium as share of salary	5.1%

AMA
AMERICAN
MEDICAL
ASSOCIATION

What is an HSA?

Since the establishment of health savings accounts (HSAs) in January 2004, HSA enrollment has risen to more than 4.5 million people. HSAs have captured attention from the media, policymakers, employers, and the general public as a possible means of managing costs and achieving greater value for health care spending. If you are considering an HSA, or are a physician with patients enrolled in HSAs—or if you just want to know what all the "buzz" is about—read on.

An HSA is a form of health insurance coverage that includes two parts:

- The health plan—a health plan with a high deductible (e.g., $1,100 for an individual or $2,200 for a family)
- The savings account—a tax-exempt personal savings account to be used for qualified medical expenses

Savings account funds are used to cover medical expenses before the plan deductible has been met. Unspent account balances accumulate and accrue interest from year to year. Once the health plan's annual deductible has been met, coverage resembles conventional insurance, typically in the form of a preferred provider organization (PPO) with little to no cost sharing for in-network services, and limits on total out-of-pocket costs.

Qualified medical expense

You can pay for a broad range of medical services out of an HSA account. Visit www.irs.gov/pub/irs-pdf/p502.pdf where these services are outlined by the Internal Revenue Service.

How does the health plan work?

Qualified high-deductible health plans (HDHPs) are available for individuals or families (two or more people), and provide coverage only after a plan's high deductible requirement has been met. You use HSA funds, or pay out-of-pocket, for any health care expenses up to the amount of the plan's deductible.

Exception: Plans are permitted to pay for preventive services before you meet your deductible. These exceptions include annual exams, immunizations, screening tests, routine prenatal and well-child care, tobacco cessation programs and obesity weight-loss programs.

How does the savings account work?

An HSA is much like an individual retirement account (IRA), except that deposits and qualified withdrawals are tax-exempt. Individuals and their employers may deposit money into an HSA up to an annual dollar limit, with extra catch-up contributions for those age 55 to 65. As of 2007, account holders can make a one-time, tax-free transfer of IRA funds to an HSA account, with the transfer counting toward the annual HSA contribution limit.

Account balances can be used to pay for a wide range of medical expenses—including some ordinarily not covered by insurance—as well as some insurance premiums. HSA funds also can be used to pay medical expenses of family members not covered by the HDHP. After reaching age 65, you may use HSA funds to augment regular income by paying ordinary income tax on withdrawals for any non-medical expenses. Like IRAs, HSA funds can be invested in stocks, bonds and mutual funds. Since you own the account, it is fully portable regardless of any job changes.

Who can have an HSA?

To be eligible to have an HSA, you must be covered by a qualified HDHP, not be enrolled in Medicare, and not be claimed as a dependent on someone else's tax return. You may not be covered by another health plan that is not a qualified HDHP, with some exceptions such as dental coverage, vision coverage, accident and disability coverage, and employee assistance programs.

Tax deductibility

HSA account deposits are deductible from taxable income even if you do not itemize deductions on your tax return. Self-employed individuals may also deduct their health insurance premiums, including premiums for HDHPs.

What if I have a chronic condition?

As with all types of health insurance, individuals applying for coverage may be subject to underwriting, benefit exclusions and pre-existing condition limitations, depending on state law. Similarly, covered benefits vary from plan to plan, including features such as personalized disease management assistance. If you have a chronic or expensive medical condition, HSA coverage could be more affordable than conventional coverage because of savings on premiums, limits on out-of-pocket spending and tax advantages.In addition, many patients with HSAs experience more control over health care decisions than under conventional health plans.

Are HSAs right for everyone?

One size does not fit all, especially when it comes to health care, which is why expanding the range of affordable coverage options is so vital. In comparing health insurance choices, take into account your anticipated health care expenses, your comfort with financial risk in the event of unexpected expenses, how much control you want over your health care choices and spending, and your current and future finances. Depending on your alternatives, you may decide that an HSA is right for you.

What dollar limits are placed on HDHPs and HSAs?

The annual allowable limits on HDHP deductibles and out-of-pocket spending, and on HSA contributions are listed below:

Minimum HDHP deductible	
Individual $1,100	Family $2,200
Maximum HDHP deductible / out-of-pocket spending	
Individual $5,500	Family $11,000
Maximum annual HSA deposit	
Individual $2,900	Family $5,800

Notes: Dollar limits are indexed annually; amounts shown are for 2008. For PPO plans, the deductible and out-of-pocket limits apply to in-network services. Due to a recent legislative change, the maximum annual account deposit is no longer limited by the plan deductible.

HSAs' first cousins: HRAs

Some employers offer HSA-style coverage legally defined as "health reimbursement arrangements" (HRAs). As with HSAs, HRAs combine a high-deductible health plan with a tax-advantaged individual account earmarked for medical expenses. In contrast to HSAs, HRAs allow greater flexibility in plan benefits (e.g., coverage of prescription drugs before the deductible has been met); only employers can contribute to HRA accounts; and HRA account balances are generally not portable when an employee leaves the company.

Patient involvement

HSAs and HRAs are part of a broad trend toward health care consumerism, involving wide-ranging efforts to help patients understand their health, medical conditions and treatment choices. More and more health plans of all types now offer comparative clinical and price information on drugs, treatments and providers, as well as features such as online health assessments, personalized health coaching, wellness programs and incentives for making healthy lifestyle choices. Changing expectations, stimulated by higher patient out-of-pocket costs, have created pressure for greater price and quality "transparency" so that patients, together with their physicians, can make more educated choices.

Once I have an HSA, how do I pay for health care services?

As with any health plan, the following applies to HSAs:

- You are entitled to plan-negotiated prices for covered services provided by in-network physicians and hospitals, even if you have not met the deductible.
- Expect to pay for services at the time you receive them (although you might be billed later if the provider can't determine what you owe without submitting an insurance claim).
- The amount you owe depends on your specific health plan benefits, the contract (if any) between your physician and your plan, and whether you have met your plan's deductible.
- Knowing your health plan benefits (including any special coverage of preventive services), whether your physician is in your plan's network, and the amount you have spent toward your deductible will help smooth your visit.
- You may receive a special credit or debit card linked to your account, with which to pay for services.

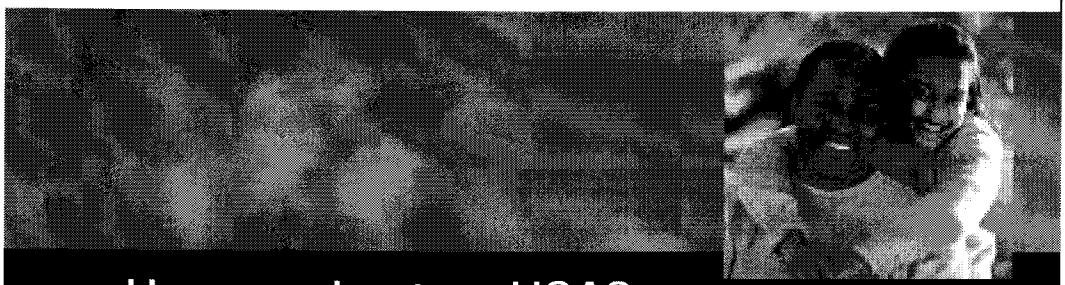
Addressing rising health care costs

An underlying premise of health care consumerism is that the more knowledgeable patients and physicians are about their options, and the clinical and financial implications they represent, the better their joint decision-making.

A corollary of this premise is that patients and physicians should help decide how to achieve better value for health care spending, rather than simply delegating cost-control to insurers or government agencies.

Why consider an HSA?

- **Protection**—you're covered against high or unexpected medical bills.
- **Affordability**—high deductibles mean lower premiums.
- **Savings**—tax advantages, account accumulations and interest earnings provide an opportunity to save for the future.
- **Flexibility**—make any number of account contributions, at any time during the year, up to April 15 of the following year.
- **Portability**—you own the account, so it goes with you regardless of any job changes.
- **Choice**—you decide which physicians or other health care professionals to see, and which treatments may be right for you.
- **Control**—most of all, an HSA puts you in greater control of your health care decisions and spending.



How can I get an HSA?

HSAs are more available than ever. If your employer does not offer an HSA, you can get an HSA on your own. However, be sure to check with a knowledgeable insurance broker about any other employee benefits you or your spouse receive that might conflict with HSA eligibility, such as a flexible spending account (FSA).

The U.S. Treasury Department offers a Web site (www.treas.gov/offices/public-affairs/hsa) that provides detailed information about HSAs and resources for locating HSA and HDHP vendors in each state.

KED:07-872:5M:9/07:df

Especially for physicians

As an early leader in developing the HSA concept and promoting such options in the health insurance marketplace, the American Medical Association (AMA) is committed to identifying the key opportunities and challenges that HSAs pose for patients and physicians. In particular, we seek to promote trends that shift health care decision-making from insurers to patients and physicians. The following guidelines are intended to help you address challenges and opportunities that may arise in your practice due to the growth of HSAs.

Helping patients understand and use HSAs:

- Be prepared to answer basic questions about HSAs and to share copies of this brochure with your patients and office staff. Additional copies are available online at www.ama-assn.org/go/hsaglance.
- Develop a sense of both the relative costs and effectiveness of procedures and treatment alternatives available to your patients, and be prepared to discuss both the financial and clinical aspects of care.
- Be on the lookout for low-to-moderate income patients who might skip their chronic care medications. If their health plan waives the deductible for preventive services, the plan might classify their medication as preventive.

Especially for physicians

HSAs are available to physicians, their families and employees through AMA Insurance Agency, Inc. Visit **www.drhsa.com** or call (877) 393-0518 for more information.

Modifying day-to-day office procedures to avoid increased collection burdens:

- Expect to revise office procedures and retrain staff regarding pricing, claims processing, collection of payment and billing so that patient payment can be collected when services are provided.
- Help educate patients about their payment responsibilities and new expectations for payment at point of service.
- Seek information from insurers about "real-time claims adjudication," which allows you to electronically file a claim and immediately learn what the health plan and patient each will pay.
- Establish a fee list for your most common services and procedures so that office staff can tell patients what they might owe in advance.
- AMA members can visit www.ama-assn.org/go/psa to obtain complimentary materials to help physicians and their office staff with the claims management process.

AMA
AMERICAN
MEDICAL
ASSOCIATION

Individual responsibility: Requiring those who can afford it to have health insurance

The American Medical Association (AMA) is committed to finding ways to expand health insurance coverage to all uninsured patients, regardless of income or health status. With relentless growth in the number of uninsured, erosion of employment-based insurance, and recognition that unpaid medical bills ultimately translate into higher insurance premiums and taxes for everyone, there is growing agreement that effective health system reform will require greater individual as well as social responsibility.

The AMA supports a modest requirement to have health insurance in order to expand coverage and strengthen the overall effectiveness of other reforms. However, individual responsibility is not a substitute for social responsibility, but rather, should be instituted in conjunction with the measures described elsewhere in this series.

Federal poverty guidelines, 2008

Number of people in family or household	Federal poverty level (FPL) as annual household income	
	FPL	500% of FPL
1	$10,400	$52,000
2	$14,000	$70,000
3	$17,600	$88,000
4	$21,200	$106,000
5	$24,800	$124,000
6	$28,400	$142,000
7	$32,000	$160,000
8	$35,600	$178,000
For each additional person, add	$3,600	$18,000

a. Source: U.S. Department of Health and Human Services, 2008. *http://aspe.hhs.gov/poverty/08poverty.shtml.*[1]

b. Applies to the 48 contiguous states and D.C.

c. Amounts are roughly 15 to 20% higher for Alaska and Hawaii.

Individual responsibility

The AMA supports a requirement that individuals and families earning more than 500 percent of the federal poverty level (FPL) obtain, at a minimum, coverage for catastrophic and preventive care, with tax implications for noncompliance. People with lower incomes would be subject to the same requirement *only* after implementation of tax credits or vouchers, awarded on the basis of financial need, for use toward the purchase of health insurance.

Based on federal poverty guidelines for 2008 (see table), 500 percent of the FPL is equivalent to $52,000 for an individual, and $106,000 for a family of four. The AMA's individual responsibility requirement would initially affect an estimated 5 million uninsured with incomes above the 500 percent FPL threshold, or 10 percent of the uninsured population.

Individuals have a responsibility to obtain health insurance when possible because of the social burden posed by those who fail to obtain coverage. The responsibility to seek and maintain coverage must be balanced by recognition that some individuals may be unable to afford health insurance without assistance. Rather than comply with the requirement to have coverage, some high-income people could choose to remain uninsured and face the tax consequences, such as the loss of a tax incentive, or the implementation of a tax penalty. The collection of additional tax revenue could then be used to offset uncompensated care of the uninsured. An individual responsibility requirement for higher-income people could be implemented immediately, prior to other health system reforms.

Assurances in exchange for having coverage

For health insurance markets to function properly, both insurers and individuals must follow fair rules of the game. In exchange for being required to have health insurance if they can afford it, insured individuals should be guaranteed that they will not lose their coverage or be singled out for premium hikes if they become ill or their health status worsens. People who maintain coverage should also have the opportunity to switch health plans periodically without being unduly penalized for any pre-existing conditions. Market regulations requiring guaranteed renewability and limited re-underwriting should be accompanied by targeted government assistance for coverage of people with predictably high medical expenses.

A requirement that low-income individuals obtain coverage will fail in the absence of appropriate subsidies and regulatory reforms. In addition, requiring greater individual responsibility must be accompanied by an assurance that coverage is affordable. The AMA is committed to increasing the value of health care spending. For more detailed information about health care costs, see "Strategies to address rising health care costs" in this series.

Advantages of requiring individual responsibility

Key reasons for requiring individuals to purchase coverage include: (a) achieving universal coverage; (b) avoiding adverse selection, whereby low-risk individuals opt out of insurance, driving up average costs and premiums for those who are insured; and (c) avoiding the free rider problem, whereby care for the uninsured is ultimately paid for by the rest of society through higher taxes and higher premiums.

The continued erosion of health insurance coverage under the current, voluntary system suggests that an approach requiring some individuals to purchase coverage may be needed to achieve near-universal coverage and to ensure that risk pools include low-risk individuals. A recent study estimates the average annual increase in insurance premiums to pay for the health care of the uninsured in 2005 was $922 for those with family coverage and $341 for those with individual coverage.[2]

Although people have more choice over whether to drive than they do over their use of health care, the free rider problem is best illustrated by automobile insurance mandates, which generally have been ineffective and difficult to enforce. Despite the near-universal prevalence of these state mandates, the cost of uninsured drivers is significant enough to affect the premiums of those who do purchase coverage. Low-income drivers are more likely to forgo car insurance—first, because of excessively high premiums, and second, because of a lack of subsidies to help purchase car insurance. Whereas laws mandating car insurance do not provide a subsidy for doing so, the AMA proposal for health insurance coverage would provide an income-related subsidy for the purchase of health insurance.

Public opinion

With the continued rise in the number of the uninsured, public opinion has grown more tolerant of individual responsibility provisions. In 2006, Massachusetts approved comprehensive statewide health system reform legislation that included provisions to increase individual responsibility, with tax penalties for individuals with incomes above 300 percent of the FPL who fail to purchase coverage. Individual responsibility provisions, including individual mandates, are also being considered by 2008 presidential candidates.

Synergistic effects of individual responsibility

Upholding clear standards of individual responsibility will enhance the impact of other elements of the AMA reform proposal. For example, in addition to directly expanding coverage, personal responsibility for having insurance would also spur the entry of average-risk people into health insurance markets, stimulating transformation of today's individual market, innovation of new purchasing arrangements, and increased insurer accountability to individuals. Giving enough people enough purchasing power—and enough say over how that purchasing power is used—will compel insurers to step up to the plate with better, more affordable coverage options. Expanding coverage will also reduce the amount of care for the uninsured ultimately paid for through higher taxes and higher premiums, breaking an upward spiral of costs and uninsured.

The individual health insurance market is already a viable option for those who would want to buy coverage rather than face tax consequences. Premiums for health insurance bought by some 7 million people on the individual market are a remarkable 60 percent lower than premiums paid for job-based insurance. These substantial premium differences are due largely to the fact that many people, when given a choice and confronted with cost trade-offs, opt for less generous coverage than is typically offered by employers. Letting individuals determine which insurance benefits are worth higher premiums is an effective means of reining in runaway health care costs, without sacrificing highly prized benefits or health care.

It should be emphasized that only those with the financial wherewithal to buy health insurance, on their own or with the help of tax subsidies, should be required to buy insurance or face tax consequences. The AMA believes that individual responsibility is not a substitute for social responsibility, and that both are needed for meaningful health care reform. Ultimately, adequate subsidies for those who need financial assistance to obtain health insurance, additional subsidies to cover high-risk patients, and fair ground rules for insurers to play by—as well as greater individual responsibility—are needed to expand health insurance coverage to all patients.

Visit *www.voicefortheuninsured.org* for more information on the AMA proposal and to view additional pieces in this series.

References

1. *Fed Regist.* Washington, DC: US Dept of Health and Human Services. 2008;73(15)3971-3972. *http://aspe.hhs.gov/poverty/08poverty.shtml.* Accessed March 21, 2008.
2. Families USA. *Paying a Premium: The Added Cost of Care for the Uninsured.* Families USA Publication No. 05-101. *www.familiesusa.org.* Published June 8, 2005. Revised July 13, 2005. Accessed November 1, 2007.

AMA AMERICAN MEDICAL ASSOCIATION

AJ:08-0368:5M:4/08 tm (4)